HERON CONNECT®

CINVANTI® (aprepitant) injectable emulsion | sustol® (granisetron) extended-release injection

Copay Assistance Program
Practice Enrollment Form

Please complete and submit by faxing to 1-844-504-8652.

1 PRACTICE INFORMATION

Practice Name: _____

Site Name (if applicable): _____

Site Address: _____

City: _____ State: _____ ZIP: _____

Check Remittance Address (if different from above): _____

City: _____ State: _____ ZIP: _____

Telephone: ( ) _____

Fax: ( ) _____

Office Contact: _____ Office Email: _____ Best Time to Call: _____

2 PROGRAM GUIDELINES

Your patients may be eligible for the Heron Connect Copay Assistance Program if they:

- Have commercial insurance that covers the prescribed medication but it does not cover the full cost; that is, they have a copay or coinsurance obligation for the prescribed medication
- Are not participating in any state or federal healthcare program, including Medicaid, Medicare, Medigap, CHAMPUS, DoD, VA, TriCare, or any state, patient, or pharmaceutical assistance program. Patients who move from commercial insurance to a state or federal healthcare program will no longer be eligible
- Live in the United States or its territories
- Are prescribed CINVANTI® and/or SUSTOL®
- Have been treated within 120 days of their enrollment date and submit their request for reimbursement within 180 days of treatment

Certain limitations apply:

Offer not valid as follows: (a) patients covered under Medicare, Medicaid, or any federal or state program; (b) where plan covers treatment for the patient for the entire cost of the prescription drug. Patients pay $0 copay per dose per 12-month calendar period. When applicable, deductible assistance up to $200 per treatment will be covered. For cash-paying patients, the program will cover $150 per prescription up to $1,800 per calendar year. Eligibility is for 12 months, after which the patient will need to reapply for continued assistance. Please see HeronConnect.com for full terms and conditions. This offer expires 12/31/2021.

To enroll specific patients in the Heron Connect Copay Assistance Program, please complete the Heron Connect Insurance Verification and Program Enrollment form, including Section 4, or complete the Heron Connect Copay Assistance Patient Registration form.

To obtain assistance for a specific claim, submit the EOB to Heron Connect via fax at 1-844-504-8652. Once received, a member of the Heron Connect team will work with you to confirm status and issue the copay assistance.

3 ATTESTATION

By participating in this program, I agree that I will not submit any third-party claims for the patient cost-sharing expenses (including copays, deductibles, and/or coinsurance) that are covered by the Heron Connect Copay Assistance Program. I also agree that I will disclose my participation in the Heron Connect Copay Assistance Program to third-party payers as required. In addition, I certify that my participation in this program is consistent with my obligations as a participating provider with any third-party payers. For the patients whom I enroll in the Heron Connect Copay Assistance Program, I attest that, prior to patient enrollment, I have obtained the written consent of the patient, or their legal representative(s), to share the patient's protected health information (PHI) with Heron Connect or programs like Heron Connect in order to obtain assistance with cost-sharing responsibilities. Further, I attest that the patients whom I enroll in the Heron Connect Copay Assistance Program do not participate in any state or federal health care program, including Medicaid, Medicare, Medigap, CHAMPUS, DoD, VA, TriCare, or any state, patient, or pharmaceutical assistance program. I attest that the information supplied is complete and accurate. I understand this information is for the sole use of the program, its representatives, and/or agents selected in order to assess eligibility for participation in the Heron Connect Copay Assistance Program. I understand eligibility under the program is subject to approval under the guidelines, and that the manufacturer reserves the right to change or terminate the program without prior notice. I agree to abide by this certification throughout the practice's participation in the program and to notify the program if aspects of this attestation are no longer applicable. By signing below, I represent that I am the prescriber or that I have the appropriate authority to sign on behalf of the prescriber and/or the practice listed on this form.

Physician or Provider Contact Signature: X _____ **Date:** _____

Name (printed): _____ Title: _____

Heron Connect Phone: 1-844-HERON-11 (1-844-437-6611); Fax: 1-844-504-8652; Hours: 8 AM-8 PM ET, M-F

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