HEALTHCARE PROVIDER REQUEST FORM

Phone: 1-866-REZZAYO (1-866-739-9296) **Fax:** 1-888-898-0033

Hours: Monday through Friday, 8:30 am – 8:00 pm ET

REZZAYO® Support Program
ASPN Pharmacies, LLC
ATTN: Pharmacist in Charge
290 W. Mt. Pleasant Ave.
Building 2, 4th Fl., Suite 4210
Livingston, NJ 07039

REZZAYO™ (rezafungin for injection)

SERVICE(S) REQUESTED

Check all that apply:
*(NOTE: Complete and sign all relevant sections on page 2)

- ☐ Benefit Verification
- ☐ Setting of Care Research
- ☐ Copay Savings Program*
- ☐ Prior Authorization Assistance
- ☐ Claims Assistance
- ☐ Patient Assistance Program (PAP)

PATIENT INFORMATION (Required)

Patient Name _____ Date of Birth _____ SSN/ID# (last 4 digits) _____

Phone# _____ US Resident? ☐ Yes ☐ No Gender ☐ M ☐ F

Patient Address _____ City _____ State _____ Zip Code _____

PATIENT INSURANCE INFORMATION (Attach a copy of both the front and back of insurance cards, if available)

Primary Insurance _____ Insurer Phone# _____ Policy# _____ Group# _____

Policy Holder's Name _____ Policy Holder's Date of Birth _____

Secondary/Supplemental Insurance _____ Insurer Phone# _____ Policy# _____ Group# _____

Policy Holder's Name _____ Policy Holder's Date of Birth _____

Check Here if Uninsured ☐

DIAGNOSIS and TREATMENT INFORMATION (Required)

Anticipated Date of Service _____ ICD-10 Code _____

PRESCRIPTION FOR REZZAYO® (REZAFUNGIN FOR INJECTION) FOR INTRAVENOUS USE

Directions	Quantity	Refills
☐ Initial 400 mg dose, followed by a 200 mg dose once weekly thereafter	_____ vials	
☐ Other: _____	_____ vials	

AUTHORIZING HEALTHCARE PROVIDER INFORMATION (Required)

Healthcare Provider Name _____ Specialty _____

Healthcare Provider Address _____ City _____ State _____ Zip Code _____

Healthcare Provider Tax ID# _____ Healthcare Provider NPI# _____

Support Program Contact Name _____ Contact Phone# _____ Contact Email _____ Contact Fax _____

Preferred Method of Contact

What is your preferred method to receive program communication? ☐ Fax ☐ Email (If checked, please provide email address _____)

(Please note: All communication is sent via fax if this is not checked)

TREATING SETTING OF CARE (At least one Setting of Care is required to complete Benefit Verification Research) (Patient Assistance Program (PAP) requests will be shipped to the address listed below. See page 2 for PAP criteria.)

Setting of Care: ☐ Hospital Inpatient ☐ Hospital Outpatient ☐ Physician's Office ☐ Infusion Center ☐ Home Infusion

Treating Facility Name _____

Facility Billing Address _____ City _____ State _____ Zip Code _____

Phone# _____ Fax# _____ Facility NPI# _____ Facility Tax ID# _____

ADDITIONAL SETTING OF CARE RESEARCH (Please complete the below section to confirm additional coverage as missing information may delay results)

Setting of Care: ☐ Hospital Inpatient ☐ Hospital Outpatient ☐ Physician's Office ☐ Infusion Center ☐ Home Infusion

Treating Facility Name _____

Facility Address _____ City _____ State _____ Zip Code _____

Phone# _____ Fax# _____ Facility NPI# _____ Facility Tax ID# _____

Setting of Care: ☐ Hospital Inpatient ☐ Hospital Outpatient ☐ Physician's Office ☐ Infusion Center ☐ Home Infusion

Treating Facility Name _____

Facility Address _____ City _____ State _____ Zip Code _____

Phone# _____ Fax# _____ Facility NPI# _____ Facility Tax ID# _____

AUTHORIZING HEALTHCARE PROVIDER CERTIFICATION AND CONSENT (Signature Required for any Service)

I certify to the best of my knowledge that the information above is accurate and complete. I have requested and received consent from the patient or the patient's guardian to enroll the patient in the designated REZZAYO® Support Programs and I agree to allow the REZZAYO® Support Programs, or its authorized representative, to review the medical, financial and insurance records for this patient at any time for the purpose of verifying the patient's eligibility status. I also attest that I have secured the patient's or the patient's guardian's written permission, to the extent and in the form required by law, to disclose the information to the REZZAYO® Support Program's authorized representative. If Patient Assistance Program (PAP) services are requested, I represent that this patient has no medical or prescription insurance coverage for the applied for drug, including all public programs; my signature further certifies that no claims for payment for product provided under the PAP will be made to any private, federal or state healthcare program, or to the patient. I further agree that the REZZAYO® Support Programs may contact me and my office via telephone, fax and e-mail regarding this enrollment request and related follow-up, and that I can revoke my consent at any time. By signing below, I certify that REZZAYO® is medically necessary and is being prescribed consistent with an FDA-approved indication based on my independent clinical judgment.

Authorizing Healthcare Provider: I have read and agree to the terms detailed on this form.

Signature _____ Sign Here Date _____

Authorizing Healthcare Provider's original signature (no stamped signatures)

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REQUIRED FOR PAP

Patient's Total Annual Household Income* $ _____ Household Size (including patient) _____

PATIENT, AUTHORIZED CAREGIVER, or AUTHORIZING HEALTHCARE PROVIDER PAP ATTESTATION and AUTHORIZATION

I attest that the information supplied above is complete and accurate, to the best of my knowledge. The patient does not receive prescription drug coverage from any government funded healthcare program, including but not limited to Medicare, Medicaid, including managed Medicaid or Tricare. I acknowledge, or, if not the patient, I acknowledge on the patient's behalf, that Melinta Therapeutics may discontinue this program or change its eligibility criteria at any time and without notice, and that the REZZAYO® Support Programs may contact me via mail, telephone, fax and e-mail regarding this enrollment request and related follow-up, and that I can revoke my consent at any time. Disclaimer: **MELINTA THERAPEUTICS** reserves the right to request additional documentation to confirm eligibility and may conduct an e-income verification which will include a soft credit check to determine household income.

Print Name: _____ Indicate Relationship to Patient: ☐ Patient (self) ☐ Authorized Caregiver ☐ Prescribing Clinician

Signature_____ Sign Here Date_____

Complete this section only if applying for the Copay Savings Program

REQUIRED FOR COPAY SAVINGS PROGRAM

Payment will be in the form of a Virtual Debit Card (VDC) via email to HCP. Please provide the HCP's email address: _____

A copy of the email will be sent to the patient. Please provide the patient's email address: _____

This email address needs to be an active email address. Please note that SPAM filters should be checked in the event they filter as SPAM. The email handle will be @amgb2b.com email address.

COPAY SAVINGS PROGRAM DISCLAIMER

Patients must be United States residents, be 18 years of age or older, and be treated in an outpatient setting of care. There is no income requirement to qualify for the copay program. The Program will cover up to $400 per 200mg vial ($800 for 400mg loading dose) of a patient's obligation, and there is no out of pocket minimum. Patient must be commercially insured. A patient will not qualify if they have a prescription drug benefit through a government program (i.e. Medicaid, Medicare, Medicare Part D, Medigap, CHAMPUS, DOD, VA, TRICARE, or any state patient or pharmaceutical assistance program). Void where prohibited by law, taxed, or restricted. Additional terms and conditions may apply. Patients enrolled in the REZZAYO® Patient Assistance Program are not eligible. Melinta Therapeutics may determine eligibility, monitor participation, and modify or discontinue any aspect of this Program at any time. For additional information regarding REZZAYO®, including Important Safety Information, please see the Full Prescribing Information available at https://rezzayo.com.

As a condition precedent of the co-payment or coinsurance support provided under this program (e.g., copay or coinsurance amounts paid to administering providers): 1) participating patients and administering providers are obligated to inform insurance companies and third-party payors of any benefits received and the value of this program, as required by contract or otherwise; and 2) administering providers may not bill patients for any amounts received under this program. Void where prohibited by law, taxed, or restricted. Additional terms and conditions may apply. Patients enrolled in the REZZAYO® PAP are not eligible for co-payment or co-insurance support.

Thank you for contacting the REZZAYO® Support Program. We are here to help you and your patients.
Please contact us at 1-866-REZZAYO (1-866-739-9296), Fax 1-888-898-0033,
or send written communication to:

REZZAYO® Support Program
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This verification of benefits is not a guarantee of payment. This verification cannot take the place of written policy information from the payer. For additional assistance please contact the REZZAYO® Support Program at 1-866-REZZAYO (1-866-739-9296).

Confidentiality notice: The information contained in this facsimile may be confidential and legally protected. It is intended only for use of the individual named. If you are not the intended recipient, you are hereby notified that the disclosure, copying, distribution, or taking of any action in regard to the contents of this fax – except its direct delivery to the intended recipient – is strictly prohibited. If you have received this fax in error, please notify the sender immediately and destroy this document and delete from your system, if applicable.

To opt-out of receiving future faxes, please contact us at 1-866-739-9296 (phone) or 1-888-898-0033 (fax).