



Questions?

Contact a Support Coordinator at 1-877-422-8360



Fax 1-240-752-6958

Copay Screening Form

Commercially insured eligible patients may lower their out-of-pocket costs to as little as \$0 with the **TOFIDENCE™ (tocilizumab-bavi) injection, for intravenous use, Drug Copay Program**. There is an annual cap on the amount of drug copay assistance that patients can receive over a one-year period. By completing this form, you will be screened to determine your eligibility for the **TOFIDENCE Drug Copay Program**.

Federal and state laws and other factors may prevent or otherwise restrict eligibility. People covered by Medicare, Medicaid, Veterans Affairs (VA), the Department of Defense (DoD), or any other federal plans are not eligible to enroll. Patients are eligible to enroll in the **TOFIDENCE Drug Copay Program** for as long as it is offered and they are treated with TOFIDENCE, provided they meet the eligibility criteria.

Biogen is committed to making access to therapy as easy as possible. If your situation ever changes, you have concerns about your ability to pay for your medication, or you have any concerns or questions about your medication, please call a Biogen Biosimilar Support Coordinator at 1-877-422-8360.

INSTRUCTIONS FOR HEALTHCARE PROVIDERS



In order for your patient to be screened for Copay Assistance, **they must be enrolled in Biogen Biosimilar Support Services and have provided their consent via signature**, either using the enrollment form or the HCP Portal, both of which can be accessed via www.tofidencehcp.com/support-services.html.

How do I complete this form?

- 1 Read, fill out, and sign as indicated in Sections I, II, and III of this Copay Screening Form. This will enable your patient to be screened for the **TOFIDENCE Drug Copay Program**.

INSTRUCTIONS FOR PATIENTS

How do I complete this form?

- 1 Read, fill out, and sign as indicated in Sections IV, V, and VI of this Copay Screening Form. This will enable you to be screened for the **TOFIDENCE Drug Copay Program**.

What happens next?

Once we receive the completed form, Biogen Biosimilar Support Services, brought to you by CareMetx, may contact you to discuss your eligibility. You can expect to receive several important notifications. You may receive a phone call from **Biogen Biosimilar Support Services** or receive an email from biosimilarsupportservices@biogen.com. Please be sure to answer when you see these calls and respond to any emails requesting your attention. They are intended to help you through your copay screening process.



THE FOLLOWING SECTIONS SHOULD BE FILLED OUT BY A HEALTHCARE PROVIDER

All fields are mandatory.

I. PATIENT INFORMATION

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
First Name	M.I.	Last Name	Date of Birth (MM/DD/YYYY)
<input type="text"/>	<input type="text"/>		
Phone Number	Email		

II. COPAY SCREENING QUESTIONNAIRE—HCP INFORMATION

1 For which of the following indications are you prescribing TOFIDENCE to treat this patient?

<input type="checkbox"/> Rheumatoid Arthritis (RA)	<input type="checkbox"/> Coronavirus Disease 2019 (COVID-19)
<input type="checkbox"/> Giant Cell Arteritis (GCA)	<input type="checkbox"/> Other, please specify
<input type="checkbox"/> Polyarticular Juvenile Idiopathic Arthritis (PJIA)	<input type="text"/>
<input type="checkbox"/> Systemic Juvenile Idiopathic Arthritis (SJIA)	

2 Are you a US-licensed physician that will be administering TOFIDENCE at a US administration site?

Yes No

III. COPAY SCREENING QUESTIONNAIRE—HCP ATTESTATION

My signature below certifies that the person named on this form is my patient, the information provided on this application, to the best of my knowledge, is complete and accurate, and that the TOFIDENCE received in response to this application is only for the use of TOFIDENCE for the patient named on this form.

My signature below certifies that the TOFIDENCE received in response to this application is only for the use of TOFIDENCE for the patient named on this form. With regard to any patient eligible for patient assistance through the Biogen Biosimilar Support Services program, I acknowledge that this medication will not be offered for sale, trade, or barter and EITHER no claim for reimbursement of either TOFIDENCE or related medical procedures and services will be submitted to Medicare, Medicaid, or any third-party payer OR I will provide appropriate denial and appeals documentation to support requests for patients who are deemed uninsured after a claim was submitted.

I consent to Biogen Inc. and its affiliates, representatives, agents, and contractors contacting me by fax, phone, mail, or email to confirm receipt of TOFIDENCE or to provide additional information about TOFIDENCE or the Biogen Biosimilar Support Services program. I acknowledge that Biogen Inc. may revise, change, or terminate any program services at any time without notice to me.

<input type="text"/>	<input type="text"/>
Name of Healthcare Provider (please print)	
<input type="text"/>	<input type="text"/>
Signature of Healthcare Provider	Date



THE FOLLOWING SECTIONS SHOULD BE FILLED OUT BY THE PATIENT

All fields are mandatory.

IV. COPAY SCREENING QUESTIONNAIRE—PATIENT

- 1** Do you consent to enrollment in the **TOFIDENCE Drug Copay Program** for assistance with copay for drug?
 Yes No
- 2** Are you currently a US citizen or US resident?
 Yes No
- 3** What is your current source of healthcare insurance and/or healthcare funding? Select all that apply.
 Private insurance (includes employer or Healthcare Marketplace insurance)
 Federal or state-funded program (includes, but not limited to, Medicare, Medicaid, VA, DoD, and TRICARE®*)
 No healthcare insurance or funding
- 4** Does your current source of healthcare insurance cover TOFIDENCE?
 Yes No I don't know
- 5** Do you currently have an out-of-pocket financial responsibility for your TOFIDENCE treatment?
 Yes No I don't know

*TRICARE® is a registered trademark of the Department of Defense, Defense Health Agency. All rights reserved.

V. PATIENT ATTESTATIONS

Please initial each statement below and attest to in writing your agreement with the following:

- I understand that if the claim for TOFIDENCE (for which I am seeking copay assistance) is reimbursed, either in whole or in part, by a federally funded insurance plan, then I am not eligible for copay assistance on such claim.
- I attest that I (i) currently do not have federally funded health insurance, (ii) will not use my federally funded health insurance to cover TOFIDENCE, and (iii) agree to notify Biogen immediately if I obtain a federally funded health insurance plan during my enrollment in the copay program(s) and choose to use it to cover any portion of the costs of TOFIDENCE so that I may be removed from the copay program(s).
- I understand that the TOFIDENCE Drug Copay Program covers only the cost of the drug and does not cover other services and fees associated with treatment, such as office visits, administration costs, additional fees, or penalties (in some plans referred to as “network penalties”) assessed by my insurance company.



THE FOLLOWING SECTION SHOULD BE FILLED OUT BY THE PATIENT

All fields are mandatory.

VI. PATIENT ADDITIONAL TERMS AND CONDITIONS

Please read and acknowledge that you understand and agree to the additional terms and conditions listed below.

- **If you are found eligible, your participation in the program and the assistance you receive will depend on you continuing to meet the following terms:**
 - You maintain coverage through an insurance provider and notify Biogen of any changes or additions to your coverage, including if you switch pharmacies or use out-of-network benefits.
 - You are taking TOFIDENCE in accordance with the Prescribing Information.
- There is an annual cap on the amount of assistance that you can receive as part of the **TOFIDENCE Drug Copay Program**. Individuals may reach this cap at different times based on a variety of factors, including but not limited to insurance coverage, claims details, and/or participation in other insurance plan-sponsored programs. Once you have reached the cap on the program, you will be responsible for paying all out-of-pocket expenses for the remainder of the calendar year. As you are nearing the cap for the **TOFIDENCE Drug Copay Program**, you will be notified via your preferred method of communication (letter or email). The **TOFIDENCE Drug Copay Program** cap will reset every January 1st.
- Biogen will not provide the copay assistance directly to you but instead will pay directly to your pharmacy or administration site on your behalf. Your pharmacy or administration site will be responsible for sending in claims for each individual date of service.
- The **TOFIDENCE Drug Copay Program** is not health insurance or a benefit plan. The program does not obligate the use of a specific provider.
- You are responsible for appropriately reporting enrollment into the **TOFIDENCE Drug Copay Program** as required by your insurer. It is your responsibility to ensure compliance with all terms of your insurance as outlined by your insurance plan.
- Biogen reserves the right to modify or discontinue the program with respect to any patient, or in its entirety, at any time. Your participation in the program does not mean that you will be entitled to receive program assistance indefinitely.

By signing below, I acknowledge that I understand the eligibility criteria for the program and agree to the terms and conditions of the program as stated above. If I fail to comply with the program, I understand that I may jeopardize my ongoing participation in the program and may be subject to the costs associated with TOFIDENCE.

If you meet any of the following criteria:

- do not agree to the terms outlined above
- are unable to answer any of the questions above
- are unable to attest that you do not have federally funded health insurance that will be used to pay for TOFIDENCE

Please call 1-877-422-8360 to notify us — do not sign and date the form.

Signature of Patient or Patient’s Legal Representative

Date

Please see full [Prescribing Information](#), including **Boxed Warning** and Medication Guide.

