

Bayer is committed to helping you with insurance, financial or affordability challenges

Your physician will initiate the request for relevant Access Services by Bayer offerings.

Access Services by Bayer can start supporting you when the patient service request form is submitted by your doctor's office. You will need to sign the form and share the following information with your doctor to complete your enrollment into Access Services by Bayer:

- Name
- Mailing Address
- Date of Birth
- Phone Number
- Email Address

Insurance information including copies of insurance cards

- Medical Insurance Carrier and Policy Number
- Pharmacy Insurance Carrier and Policy Number
- Secondary Insurance Carrier and Policy Number, if applicable

Remember, we need your signature in order to process your Access Services by Bayer request. Please work with your doctor to sign the form.

When submitting this information to your physician for enrollment in Access Services by Bayer, please know that you are consenting to the uses of your information outlined on page 2.



**For more information call
Access Services by Bayer at 1-800-288-8374**


Jivi[®]
antihemophilic factor
(recombinant) PEGylated-aucI


Kovaltry[®]
Antihemophilic Factor (Recombinant)

Access Services

by Bayer™



PATIENT HIPAA AUTHORIZATION

I voluntarily provide this authorization for the use and disclosure of my Protected Health Information (“PHI”), as such term is defined by the Health Insurance Portability and Accountability Act of 1996 (as amended, “HIPAA”). I understand that PHI is health information that identifies me or that could reasonably be used to identify me.

I authorize my healthcare provider, including my physician and pharmacy, and my health plan, to disclose to Bayer and its contracted agents my name, address, telephone number, health insurance status and coverage and such medical information as may be necessary for me to enroll in Access Services by Bayer™. I understand this disclosure(s) will contain PHI, including information about my current medical condition, treatment, coordination of treatment and receipt of medication. I allow the use and disclosure of my PHI to Bayer its contracted agents for the following purposes:

- To verify my insurance information and coverage
- To ensure the accuracy and completeness of the Access Services by Bayer™ Enrollment Form
- To help with my insurance coverage questions for Bayer medications
- To determine if I qualify for other Bayer patient support programs
- To determine my eligibility for other sources of prescription medication financial assistance
- To provide education, training, and ongoing support on the use of my Bayer medication
- To send me information on Bayer products and services related to my treatment
- To send me refill reminders for my Bayer prescription medication and to encourage its appropriate use
- To communicate with me, my healthcare providers and health plan about my medical care and treatment
- To contact me for market research feedback, sales support purposes, and as necessary to comply with applicable laws
- Bayer may contact you for potential adverse event follow-up information

I understand that:

- This Authorization will remain in effect until the end of my participation in Access Services by Bayer™ or 5 years, unless subject to applicable law from the date of my signature on this Authorization, whichever occurs later.
- I may cancel this Authorization at any time by writing to: Access Services by **Bayer, PO BOX 2230, Columbus OH 43216**.
- If I cancel this Authorization my healthcare provider and health plan will stop sharing my PHI with Bayer and its contracted agents. However, the revocation will not affect prior use or disclosure of my PHI in reliance on this Authorization.
- I may opt-out of being contacted for market research feedback, sales support purposes and still enroll in the patient support program.
- That entities that receive my PHI in accordance with this Authorization may not be required by law to keep the information private and that it will no longer be protected by the HIPAA privacy law. It may become available in the public domain.
- I do not need to sign this Authorization to receive (i) medical treatment or medication or (ii) coverage, payment, enrollment in or eligibility for benefits from my health plan. However, if I do not sign this Authorization, I may not participate in Access Services by Bayer™ or be eligible for other Bayer patient support programs.
- I understand that some of my health care providers, such as my pharmacies, may receive payment from Bayer in return for services that require use or disclosure of my PHI to Bayer and its contracted agents.

I have read and understand the terms of this Authorization and have had an opportunity to ask questions about the uses and disclosures of PHI. I understand that I am entitled to receive a signed copy of this Authorization and I can also get a copy by contacting Access Services by Bayer™ at 1-800-288-8374.


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Antihemophilic Factor (Recombinant)