Provider Co-pay Claim Reimbursement Request Form

BEOVU Program, PO Box 221706, Charlotte, NC 28222 PHONE: 1-888-61-BEOVU (23688) FAX: 1-800-266-6799

Please fill out this form, one per physician, one time per site, for co-pay reimbursement for BEOVU®. If a physician is affiliated with another site, this form will need to be filled out again with the provider signature at the bottom. **All fields are required on this form.** Patient subject to combined annual limit of $12,000. Please see below for full program Terms and Conditions.

HEALTH CARE PROVIDER INFORMATION

Step 1

Provider's Last Name: _____ Provider's First Name: _____

Provider's NPI: _____ State License #: _____

Site Name: _____ Site NPI: _____

Preferred Method of Payment (check one): ☐ Check ☐ Virtual Debit ☐ EFT (electronic fund transfer)
Chosen method will be for all payments. To change your method of payment, please fill out this form again.

Email: _____ Site Address: _____
(required for EFT)

Site City: _____ Site State and Zip Code: _____

Step 2

To set up co-pay reimbursement for a physician at a specific site, please fax this form, Provider Co-pay Claim Reimbursement Request Form (one time only), to 1-800-266-6799

For each claim, please also fax the following documents:

☐ Patient Explanation of Benefits (EOB) form

☐ CMS-1500 or CMS-1450/ UB-04/ UB-92 form

☐ Copy of primary insurance card (front and back) (one time only per patient unless change in insurance)

BEOVU GO™ Terms & Conditions

Limitations apply. Valid only for those with private insurance. Program may include the Co-pay Card, Payment Card (if applicable), and Rebate, with a combined annual limit up to $12,000. For patients covered under the medical benefit, rebate for patient's out-of-pocket costs will be assigned directly to provider, unless patient requests direct reimbursement. Patient is responsible for any costs once limit is reached in a calendar year. Program not valid (i) under Medicare, Medicaid, TRICARE, VA, DoD, or any other federal or state health care program, (ii) where patient is not using insurance coverage at all, (iii) where the patient's insurance plan reimburses for the entire cost of the drug, or (iv) where product is not covered by patient's insurance. The value of this Program is exclusively for the benefit of patients and is intended to be credited toward patient out-of-pocket obligations and maximums, including applicable co-payments, coinsurance, and deductibles. Program is not valid where prohibited by law. Patient may not seek reimbursement for the value received from this Program from other parties, including any health insurance program or plan, flexible spending account, or health care savings account. Patient is responsible for complying with any applicable limitations and requirements of their health plan related to the use of the Program. Valid only in the United States and Puerto Rico. This Program is not health insurance. Program may not be combined with any third-party rebate, coupon, or offer. Proof of purchase may be required. Novartis reserves the right to rescind, revoke, or amend the Program and discontinue support at any time without notice.

CERTIFICATION STATEMENT

I certify that the information provided herein and for all patient documentation I submit for BEOVU co-pay reimbursement at this site is accurate; that expenses requested for payment are eligible, actually incurred, and not paid by the patient's insurance, flexible spending account, health savings account, or any other payer; and that I would, in the ordinary course of my practice, have charged my patient for such out-of-pocket expenses and have not done so. I also certify that every patient for whom I submit for co-pay reimbursement and receive co-pay reimbursement (i) is not insured under Medicare, Medicaid, TRICARE, or any other government (state or federally funded) program, and (ii) meets the other eligibility criteria specified in the Terms and Conditions above. I understand that I am liable for any misrepresentations herein to the full extent of applicable law.

Acknowledged and Agreed: _____ Date: _____
Provider signature (required)

NOVARTIS

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Beovu® (brolucizumab-dbll) Injection