

Xofigo® Access Services Enrollment Form

For Use by VA/DoD Only

Xofigo (radium Ra 223 dichloride) Injection

1. Fax a **completed** Xofigo Access Services Enrollment Form **including the signed Patient Authorization** (page 2 of this form) to **1-855-963-4463**, or call us at **1-855-6XOFIGO** (1-855-696-3446) to confirm a treatment date/schedule. At a minimum, please provide your patient's first scheduled treatment date/time. Access Counselors are available from 9:00 AM to 7:00 PM ET (M-F). You can also log onto the Xofigo Access Services Provider Portal 24 hours a day, 7 days a week at **XofigoAccessOnline.com**.
2. Call Xofigo Access Services up to 7 business days prior to each scheduled treatment to verbally place the order with Cardinal Health Nuclear Pharmacy Services. **Please be sure to identify yourself as a VA/DoD physician.** Orders can also be placed online via the secure Provider Portal.
3. If you have not placed the order **a minimum of 3 business days** prior to the scheduled treatment date, Xofigo Access Services will call you to process the order.

Administering Provider Information

Administering Provider Name: _____ Specialty: _____
State License #: _____ Federal Government Tax ID #: _____
Facility Name: _____
Facility Address: _____
City/State/Zip Code: _____
Primary Contact Name: _____
Phone: _____ Extension: _____ Fax: _____

Patient Information

Patient Name: _____ Patient Email: _____ Patient DOB: _____
ICD-10 Primary dx (check box): C61 Other _____ ICD-10 Secondary dx: C79.51 C79.52 Other _____

Treatment Dates and Times

Treatment 1: _____ Treatment 2: _____
Treatment 3: _____ Treatment 4: _____
Treatment 5: _____ Treatment 6: _____

Referring Provider Information (Referring physicians often request treatment updates, please provide the following information)

Physician Name/Contact Name: _____ Referring Provider Specialty: _____
Referring Facility: _____ Phone: _____
Facility Address: _____ City/State/Zip Code: _____

Product Shipping Information

Ship-To Facility Name: _____ Ship-To Contact Name: _____ Phone: _____
Address: _____ City/State/Zip Code: _____
Operating Hours (Day and Time): _____ Delivery Instructions: _____

Physician Declaration

I verify that the information contained in this inquiry form is complete and accurate to the best of my knowledge. I understand that Bayer reserves the right to modify or terminate Xofigo Access Services at any time and without notice. I understand that Bayer is not responsible for filing claims and that all final decisions on diagnosis, the need for treatment, and the appropriateness of Xofigo for a particular patient rest with me as the patient's provider. I agree to abide by this certification throughout my participation in Xofigo Access Services.

Physician Signature: _____ Date: _____

Patient Authorization for Xofigo® Access Services

I authorize the use and/or disclosure of my private health information, described below, which may include “Protected Health Information” or “PHI” as defined by the Health Insurance Portability and Accountability Act of 1996, as amended (“HIPAA”). In general terms, I understand that Protected Health Information is health information that identifies me or that could reasonably be used to identify me. I understand that this authorization is voluntary.

I authorize my healthcare providers that treat me or provide healthcare services to me, including my physicians and pharmacies, and my health insurer(s) to share or disclose my name, address, and telephone number, along with certain medical records and insurance and financial information with respect to my treatment; my eligibility for insurance or patient assistance; the coordination of my treatment, including scheduling, ordering, and the receipt of my medication; and my participation in the Xofigo Access Services (the “Program”) to Bayer and its agents. These agents include a company that is an administrative contractor that administers the Program, the supplier which dispenses Xofigo, and a data analytics company which analyzes and produces reports of aggregated data (collectively “Bayer”). I understand that certain healthcare providers may receive payment or other forms of remuneration from Bayer in connection with the use and disclosure of my PHI as described in this authorization.

I allow the use and disclosure of my PHI for the following purposes: (1) to verify my financial or insurance information; (2) to ensure the accuracy and completeness of the Program enrollment form; (3) to help with my reimbursement questions; (4) to see if I qualify for patient assistance or copayment assistance or to refer me to, or determine my eligibility for, other programs, foundations, or alternate sources of funding or coverage to help me with the costs of obtaining Xofigo; (5) to coordinate my Xofigo treatments; (6) to send me educational materials, or other Program information that may be of interest to me; (7) for commercial purposes, including to understand how Xofigo is used across healthcare providers and other market research; (8) to manage supply and availability of Xofigo for my treatments; (9) to follow up with my healthcare providers or myself with regard to any reported adverse event / product technical complaint / incident or other safety related information; and (10) to comply with applicable law.

This authorization expires at the end of my participation in the Program or 3 years (or earlier if required by state law) from the date of my signature, whichever comes first. I can withdraw (ie, take back) this authorization any time, except to the extent my healthcare provider or health plan insurer has taken action in reliance on my authorization. I understand that if I revoke this authorization, it will not have any effect on any actions my healthcare providers or my health plan may have taken before receiving the revocation, and will not affect Bayer’s ability to use and disclose any information it has already received. I can withdraw this authorization by mailing a written request to Xofigo Access Services, PO Box 220009, Charlotte, NC 28222-0009, or by faxing a request to 1-855-963-4463. I also understand that persons or entities that receive my PHI under this authorization may not be required by privacy laws (such as the HIPAA Privacy Rule) to protect the information and may share it with others without my permission, if permitted by laws applicable to them.

My healthcare providers and health plan insurer will not condition my medical treatment or its payment, insurance enrollment, or eligibility for insurance benefits on my signing this form. However, if the information requested about me is not provided, Bayer will be unable to determine my eligibility to participate in an available patient assistance program or copayment assistance program and, thus, I may be unable to participate in these programs. I have read this authorization and/or had its contents read to me. I have had an opportunity to ask questions about the uses and disclosures of PHI described above and all of my questions have been answered to my satisfaction. I authorize the use and disclosure of my information as described in this form. I understand that I am entitled to receive a signed copy of this authorization.

Print Patient’s or Patient Representative’s Name: _____ Date: ____ / ____ / ____

Patient’s or Patient Representative’s Signature: _____ Date: ____ / ____ / ____

If signed by the Patient’s Representative, include a description of the Representative’s relationship to the Patient and such person’s authority to act for the Patient (eg, parent, guardian, etc)

