



The Organon Access Program Enrollment Form

Phone: 1-866-809-9515 | Fax: 1-866-806-0775
Email: organonaccess@connectiverx.com

For co-pay only enrollment, please visit: <https://hcp.organonaccessprogram.com/hcp>

Required fields are marked with an asterisk (*).

PATIENT INFORMATION			
Last Name*:	First Name*:	Date of Birth*:	Patient Gender: () F () M
Street Address*:			
City*:	State*:	Zip Code*:	
Home Phone: () check if preferred	Mobile Phone: () check if preferred	Patient Email:	
Caregiver Name (if applicable):	Relationship to Patient:	Phone:	

PATIENT INSURANCE INFORMATION			
Insurance Cards Attached: () Y () N () No Insurance Include front and back copies of insurance cards (Medical AND Pharmacy, if separate) with each submission.			
Primary Insurance*:		If patient is insured, the insurance is: <input type="checkbox"/> Commercial or <input type="checkbox"/> Government	
Policyholder Name:		Policyholder Date of Birth:	
Insurance Company Phone Number:		Relationship to Policyholder:	
Policy ID Number*:		Group Number:	
Rx Insurance Name:	Rx Policy ID Number:	Rx Group ID Number:	
Rx BIN:	Rx PCN:		

SECONDARY INSURANCE INFORMATION			
Secondary Insurance:			
Policyholder Name:		Policyholder Date of Birth:	
Insurance Company Phone Number:		Relationship to Policyholder:	
Policy ID Number:		Group Number:	
Rx Insurance Name:	Rx Policy ID Number:	Rx Group ID Number:	
Rx BIN:	Rx PCN:		

ORGANON CO-PAY ASSISTANCE PROGRAM – TERMS AND CONDITIONS

I certify that I have read and understand the Terms and Conditions of the Organon Co-pay Assistance Program. I certify that I meet the eligibility requirements listed in the Terms and Conditions and that the information I am providing on this form is true and correct. I certify that I have private insurance and that no part of the costs associated with the Program Product for which I am seeking a benefit under the Co-pay Assistance Program was or will be covered or reimbursed by a Government Program, as that term is defined in the Co-pay Assistance Program Terms and Conditions. I understand that if I begin to have coverage under any Government Program or if my state prohibits the redemption of manufacturer co-pay assistance (coupons) at any time, I will no longer be eligible to receive benefits under the Co-pay Assistance Program. If I am enrolled in a qualified health plan purchased through a health insurance exchange established by a state government or the federal government ("QHP"), I understand that if the federal government or my state government prohibits the redemption of manufacturer co-pay assistance (coupons) by enrollees in QHPs at any time, I will no longer be eligible to receive benefits under the Co-pay Assistance Program. I certify that my insurance company has not prohibited the redemption of manufacturer co-pay assistance (coupons) for the Program Product, and I understand that if at any time my insurance company prohibits the redemption of manufacturer co-pay assistance (coupons) for the Program Product, I will no longer be eligible to receive benefits under the Co-pay Assistance Program.

A copy of the Terms and Conditions for this program can be found at: <https://www.organonaccessprogram.com/copay-terms>.

I have read, understand, and agree with all of the above Terms and Conditions.

Patient Signature: _____

Date: _____

Legal Representative Name (Print): _____

Legal Representative Relationship to Patient: _____

PATIENT AUTHORIZATION FOR USE/DISCLOSURE OF HIPAA PROTECTED HEALTH INFORMATION

By signing below, I authorize my physicians, pharmacist, and other health care providers (“Providers”) and my health insurers (“Insurers”) to disclose information about my medical condition and treatment, health insurance and policy number, and any other information provided in this enrollment form, in the Organon Patient Assistance Program enrollment form, as applicable, as well as further information needed to process my enrollment (HIPAA “Protected Health Information” or “PHI”), to Organon, LLC, and Organon Patient Assistance Program Inc., the sponsors of The Organon Access Program and the Organon Patient Assistance Program (individually, a “Program,” collectively, the “Programs”), respectively, and their agents, service providers, contractors, and representatives (“Organon”) so that Organon may operate the Programs. This includes to: (i) verify my eligibility and enroll me in the Program for which I qualify; (ii) provide the services requested in this enrollment form, which may require the disclosure of my PHI by Organon to my Providers, Insurers, and Medicare; (iii) contact me via email, text message, telephone, or US postal mail and other communication channels I opt in to for Program-related purposes; (iv) ensure compliance with applicable laws and monitor, audit, and evaluate the Program’s implementation and effectiveness; (v) use de-identified information for data analysis purposes; (vi) disclose my PHI to third parties relating to a corporate reorganization, merger, sale, joint venture, assignment, transfer, or other disposition of all or any portion of its business, assets, or stock, including regarding any bankruptcy or similar proceedings. I further authorize Organon to use and disclose my PHI for these Program purposes.

I understand that I do not need to sign this Authorization in order to receive health care treatment or insurance benefits but that if I do not sign the Authorization, I will not be able to obtain assistance from the Programs. I also understand that once PHI is disclosed to Organon pursuant to this authorization, it may no longer be protected by HIPAA.

I understand that I may cancel this Authorization at any time by calling 1-866-809-9515 or by mailing a written request to **The Organon Access Program, PO Box 2355, Morristown, NJ 07962**. I understand that canceling this Authorization will not invalidate uses and disclosures of my PHI made in reliance on the Authorization before Organon received notice of my cancellation. Unless canceled earlier, the Authorization will remain in effect for 3 years from the date of signature or for the maximum period allowed by applicable state law, if less than 3 years. Organon will retain the information I have submitted in accordance with its records retention policy. I understand that I am entitled to receive a copy of this authorization once it has been signed.

I have read this authorization or have had it explained to me.

Patient Signature (If the patient is under 18 years of age or a legal guardian has been appointed, a legal representative should sign and print their name):

Date: _____

Legal Representative Name (Print): _____

Legal Representative Relationship to Patient: _____

CONSENT TO COLLECTION AND USE OF PERSONAL INFORMATION, PREFERRED COMMUNICATION CHANNELS, AND ADDITIONAL OPTIONAL CONTACT OPPORTUNITIES

By signing below, I consent to Organon's collection and use of my personal information, including information related to my health, for the Program purposes described above and to contact me via email, text message, telephone, or US postal mail for Program-related purposes. I understand that I can revoke this consent at any time, but doing so will mean that I will no longer be able to receive the Program services. Further information concerning Organon's collection and processing of personal information, including the rights of individuals with respect to such processing, is available at www.organon.com/privacy.

(Optional) By checking this box, I consent to receive Program-related texts, including communications which may be considered to be marketing, from and on behalf of The Organon Access Program, made with an automatic text messaging system, at the cell phone number for me (the Patient) provided on this form. I understand that I do not need to provide this consent in order to purchase any Organon products. I understand that text message and data rates may apply. Frequency may vary. Reply STOP to cancel, HELP for help. Terms and Conditions and Privacy Policy apply. To view the Privacy Policy, go to www.organon.com/privacy. See [Terms and Conditions](#) for the SMS terms.

Mobile Phone #: _____

(Optional) By checking this box, I consent to receive Program-related calls, including communications which may be considered to be marketing, from and on behalf of The Organon Access Program at the cell phone number for me (the Patient) provided on this form. I understand that these calls may be autodialed and/or include prerecorded content or an artificial voice. I understand that I do not need to provide this consent in order to purchase any Organon products and that I can revoke this consent at any time by calling 1-866-809-9515.

The Organon Access Program SMS (text) messages are recurring automated savings program messages, which include a digital savings card and refill reminder messages. These SMS messages are sent through PSKW, LLC, dba ConnectiveRx, a service provider partner operating on behalf of Organon, LLC ("Organon"). When you opt in to the service, we will send you an SMS message to confirm your sign-up. By providing your cell phone number, you represent that you are the authorized user of the wireless device you use to receive the messages and that you are authorized to approve any changes. Organon reserves the right to alter these Terms and Conditions or discontinue the messaging at any time and, at its sole discretion, may add or delete a cellular carrier from this program at any time, without notice. Text messages you receive as part of this program are automated, and your responses are not read by any person. Consent to receiving SMS messages is not a requirement to participate in The Organon Access Program, and you may opt out at any time. Please visit Organon's Privacy Policy at www.organon.com/privacy or contact us for additional information. Please visit the full Terms and Conditions regarding participation eligibility in The Organon Access Program. Message and data rates may apply. While we do not charge you for the messages, your mobile service provider may charge you for SMS messages as a part of your contract or service. Please contact your mobile service provider for details. Message frequency varies. To stop receiving messages, reply STOP at any time. For help, reply HELP or call 1-866-809-9515. We are able to deliver on most of the major and minor carriers, eg, Verizon, Sprint, AT&T, T-Mobile, and MetroPCS. If you are unsure whether your carrier supports short codes, please contact your wireless provider directly. Carriers are not liable for delayed or undelivered messages.

Patient Signature (If the patient is under 18 years of age or a legal guardian has been appointed, a legal representative should sign and print their name.): _____

Date: _____

Legal Representative Name (Print): _____

MEDICATION (SELECT ONE)

<input type="checkbox"/> BILDYOS® (denosumab-nxxp) injection 60 mg/mL in a single-dose prefilled syringe Prescribing Information Medication Guide	<input type="checkbox"/> BILPREVDA® (denosumab-nxxp) injection 120 mg/1.7 mL (70 mg/mL) single-dose vial Prescribing Information	<input type="checkbox"/> ONTRUZANT® (trastuzumab-dttb) injection, for intravenous use Select one: <input type="checkbox"/> 150-mg single-dose vial <input type="checkbox"/> 420-mg multiple-dose vial Prescribing Information including Boxed Warning	<input type="checkbox"/> RENFLEXIS® (infliximab-abda) injection, for intravenous use 100-mg single-dose vial Prescribing Information including Boxed Warning Medication Guide
--	---	---	--

Dosing/Quantity/Refills

Initial dose: Quantity: ____ Refills: 0
Directions for use: _____

Maintenance dose: Quantity: ____ Refills: ____
Directions for use: _____

How will you access the medication? (Check one for BILDYOS, BILPREVDA, or RENFLEXIS)

Buy and Bill via Medical Benefit (order through distributor)
 Pharmacy

Request to Triage to Pharmacy? Yes or No If yes, please provide the following:

HCP Preferred Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Fax Number: _____

CLINICAL INFORMATION (IMPORTANT INFORMATION INTENDED TO ASSIST WITH THE PRIOR AUTHORIZATION PROCESS)

All applicable ICD-10 Diagnosis Codes (required, maximum of 2):

PRESCRIBER INFORMATION (SHIP TO ADDRESS AND LOCATION)*

Prescriber Last Name*:		Prescriber First Name*:		NPI Number*:	
Tax ID #*:					
Practice Name:		Office Phone:		Office Fax*:	
Street Address*:					
City*:		State*:		Zip*:	
Office Contact Name:			Office Contact Phone (with extension):		
Office Contact Email:					
Site of Administration*: <input type="checkbox"/> Physician Office <input type="checkbox"/> Outpatient Treatment Center <input type="checkbox"/> Ambulatory Surgery Center <input type="checkbox"/> Infusion Center					
If Site of Administration is Not the Physician Office, Please Fill Out the Following Information:					
Site of Administration Name:		Office Phone:		Office Fax:	
Street Address:					
City:		State:		Zip:	
NPI #:		Tax ID #:		Location PTAN:	

HEALTH CARE PROVIDER ATTESTATION (MUST CONTAIN ORIGINAL SIGNATURE)*

By signing below, I represent and warrant the following:

- This enrollment form has been prepared exclusively by the health care provider or health care provider's office identified in this enrollment form ("my Practice").
- By signing below, I represent and warrant that I am authorized pursuant to the laws of my state of license to prescribe this medication.
- I or others in my health care provider practice group ("my Practice") have obtained written authorization from the patient named in this enrollment form that complies with the requirements of the HIPAA Privacy Rule, 45 C.F.R. § 164.508, and authorizes me and my Practice, as well as the patient's health insurance plan(s), to disclose the patient's personal health information ("PHI"), including information relating to the patient's medical condition and prescription medications and the information disclosed in this enrollment form to The Organon Access Program (the "Access Program"), and the Organon Patient Assistance Program ("Organon PAP") (individually, "a Program"; collectively, "the Programs"), and the administrators of the Programs, its affiliates, contractors, and other third parties providing services related to these programs (collectively, "Program Administrators"), and authorizes the Programs and its Program Administrators to use and disclose the PHI for purposes of benefits investigation and reimbursement support.
- I certify that I, or a health care provider in my Practice, have determined that the prescribed product is medically appropriate for the patient identified above and that I, or a health care provider in my Practice, will be supervising the patient's treatment.
- If the patient receives product through the Organon PAP, neither I nor my practice will seek reimbursement for such product administered to the patient from any source.
- Neither I nor my Practice will receive any reimbursement from Organon, whether for administration fees or otherwise.
- I understand that information concerning Program participants may be summarized for statistical or other purposes and provided to Organon and/or the Programs only for use in an aggregated, de-identified format.
- I and my Practice grant the Programs the right to conduct periodic audits of my Practice's records to verify the information provided herein, excluding patient identifiable data (unless the auditor enters into an appropriate agreement with my Practice to protect an individual's medical privacy).
- I consent to receive communications related to the Program by telephone, email, and/or fax.
- I understand that the Program reserves the right to modify or discontinue this program at this facility/practice or terminate assistance at any time and without notice.
- I verify that the information provided is complete and accurate to the best of my knowledge.

Health Care Provider Signature: _____

Date: _____

HEALTH CARE PROVIDER CERTIFICATION: THE ORGANON CO-PAY ASSISTANCE PROGRAM

I, a licensed health care professional, certify that the Program Product has been prescribed to the patient indicated on this form in the exercise of the prescriber's independent medical judgment for an FDA-approved indication.

I have read and agree to the Terms and Conditions of the Co-pay Assistance Program.

I certify that, to the best of my knowledge, the patient data meets the criteria set forth in the Terms and Conditions and that the information I am providing on this form is true and correct.

I certify that I/my office will not take into account the fact that the patient may receive a benefit from the Co-pay Assistance Program when determining the amount of any charge(s) to the patient.

I certify that I/my office will not charge the patient any fee to complete this form and I/my office will not advertise or otherwise use the Co-pay Assistance Program as means of promoting my services or the Program Product.

I certify that I/my office will not seek reimbursement for all or any part of the benefit received by the patient through the Co-pay Assistance Program.

MEDICAL BENEFIT ONLY:

I certify that the claim I submit/my office submits to the patient's private health insurer for payment of the Program Product will have the Program Product listed separately from any claim for medication administration or any other items or services provided to the patient.

I understand that I am/my office is responsible for reporting receipt of Co-pay Assistance Program benefits to any insurer, health plan, or other third party who pays for or reimburses any part of the medication cost paid for by the Co-pay Assistance Program, as may be required.

I understand that the patient's benefit received under the Co-pay Assistance Program may be paid directly to me/my office by the Co-pay Assistance Program on behalf of my patient or, if my patient has already paid the patient's share of the cost of the Program Product, may be paid directly to the patient. I/my office will apply any amounts received from the Co-pay Assistance Program to the satisfaction of the patient's obligation for the cost of the Program Product only. If the patient's Co-pay Assistance Program benefit is paid to me/my office on behalf of my patient and I/my office already received payment from the patient for the patient's share of the cost of the Program Product, I/my office will refund the amounts received (minus the patient's obligation per administration in accordance with the Co-pay Assistance Program Terms and Conditions) back to the patient.

I understand and agree that the certifications I am providing in this Health Care Provider Certification apply to the patient indicated on this form and to any other patient enrolled in the Co-pay Assistance Program who I treat with the Program Product and any claim I submit/my office submits for Co-pay Assistance Program benefits on the patient's behalf. I understand that I may be asked to sign a new Health Care Provider Certification if the Terms and Conditions of the Co-pay Assistance Program for the Program Product changes.

By signing, I certify that I have read and agree to the above Attestation. I also have read and agree to the above Certification (if applicable based on the support my patient requested) on behalf of the health care provider and all health care providers associated with the Practice/facility Tax Identification Number, Practice/facility name, and address associated with this Certification ("Recipient"). All health care providers affiliated with the Practice/facility may be jointly and severally liable hereunder. I further certify that I am authorized to make such attestation on behalf of the Recipient. The Certification above is not an exhaustive list and the Recipient agrees to comply with any other applicable laws, statutes, and regulations in regards to co-pay reimbursement programs.

Health Care Provider Signature: _____

Health Care Provider Name (please print): _____

Health Care Provider Designation (MD, DO, NP, PA, Other): _____

To report an adverse event to a specific Organon product, including death due to any cause, please contact the Organon Service Center at 1-844-674-3200.