

HEALTHCARE PROVIDER REQUEST FORM

Phone: 1-844-ORBACTIV (1-844-672-2284) Fax: 1-855-886-2482
Hours: Monday through Friday, 8am – 8pm ET

ORBACTIV® Support Programs
ASPN Pharmacies, LLC
290 W. Mt. Pleasant Ave
Building 2, 4th Fl., Suite 4210
Livingston, NJ 07039



SERVICE (S) REQUESTED

Check all that apply: Insurance Benefit Verification Prior Authorization Assistance
(**NOTE: Complete and sign all relevant sections on page 2*) Include KIMYRSA insurance verification Claims Assistance
 Setting of Care Research Patient Assistance Program (PAP)*
 Copay Savings Program*

PATIENT INFORMATION (Required)

| | | | |
|-----------------|---|--|----------|
| Patient Name | Date of Birth | SSN/ID# (last 4 digits) | |
| Phone# | US Resident? <input type="checkbox"/> Yes <input type="checkbox"/> No | Gender <input type="checkbox"/> M <input type="checkbox"/> F | |
| Patient Address | City | State | Zip Code |

PATIENT INSURANCE INFORMATION (Attach a copy of both the front and back of insurance cards, if available)

| | | | |
|--|-------------------------------|---------|--------|
| Primary Insurance | Insurer Phone# | Policy# | Group# |
| Policy Holder's Name | Policy Holder's Date of Birth | | |
| Secondary/Supplemental Insurance | Insurer Phone# | Policy# | Group# |
| Policy Holder's Name | Policy Holder's Date of Birth | | |
| Check Here if Uninsured <input type="checkbox"/> | | | |

DIAGNOSIS and TREATMENT INFORMATION (Required)

Anticipated Date of Service: _____ ICD-10 Code: _____

AUTHORIZING HEALTHCARE PROVIDER (HCP) INFORMATION (Required)

HCP Name: _____ Specialty: _____
HCP Tax ID# _____ HCP NPI# _____

Contact for Support Program Correspondence:

Name: _____ Phone# _____ Fax# _____ Email: _____

Preferred Method of Contact

What is your preferred method to receive program communication? Fax Email (If checked, please provide email address: _____)
(Please note: All communication is sent via fax if this is not checked)

TREATING SETTING of CARE (At least one Setting of Care is required to complete Drug Benefit Verification Research) (Patient Assistance Program (PAP) requests will be shipped to the address listed below. See Page 2 for PAP criteria.)

Setting of Care: Hospital Inpatient Hospital Outpatient Physician's Office Infusion Center Home Infusion ER

Treating Facility Name _____

| | | | |
|--------------------------|------|-----------------------|------------------|
| Facility Billing Address | City | State | Zip Code |
| Phone# | Fax# | Facility Billing NPI# | Facility Tax ID# |

ADDITIONAL SETTING OF CARE RESEARCH (Please complete the below section to confirm additional coverage, missing information may delay results)

Setting of Care: Hospital Inpatient Hospital Outpatient Physician's Office Infusion Center Home Infusion ER

Treating Facility Name _____

| | | | |
|------------------|------|---------------|------------------|
| Facility Address | City | State | Zip Code |
| Phone# | Fax# | Facility NPI# | Facility Tax ID# |

Setting of Care: Hospital Inpatient Hospital Outpatient Physician's Office Infusion Center Home Infusion ER

Treating Facility Name _____

| | | | |
|------------------|------|---------------|------------------|
| Facility Address | City | State | Zip Code |
| Phone# | Fax# | Facility NPI# | Facility Tax ID# |

Not required but please include, if available.

AUTHORIZING HEALTHCARE PROVIDER CERTIFICATION AND CONSENT (Signature Required for any Service)

I certify to the best of my knowledge that the information above is accurate and complete. I have requested and received consent from the patient or the patient's guardian to enroll the patient in the designated ORBACTIV® Support Programs and I agree to allow the ORBACTIV® Support Programs, or its authorized representative, to review the medical, financial and insurance records for this patient at any time for the purpose of verifying the patient's eligibility status. I also attest that I have secured the patient's or the patient's guardian's written permission, to the extent and in the form required by law, to disclose the information to the ORBACTIV® Support Program's authorized representative. If Patient Assistance Program (PAP) services are requested, I represent that this patient has no medical or prescription insurance coverage for the applied drug, including all public programs; my signature further certifies that no claims for payment for product provided under the PAP will be made to any private, federal or state healthcare program, or to the patient. I further agree that the ORBACTIV® Support Programs may contact me and my office via telephone, fax and e-mail regarding this enrollment request and related follow-up, and that I can revoke my consent at any time.

X _____  _____ Date _____
Authorizing HCP's original signature (no stamped signatures) Authorizing HCP: I have read and agree to the terms detailed on this form.

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PATIENT INFORMATION (Required)

Patient Name: _____

Date of Birth: _____

Complete this section only if applying for the Patient Assistance Program (PAP)

REQUIRED FOR PAP

Patient's Total Annual Household Income* \$ _____

Household Size (including patient) _____

PRESCRIPTION FOR ORBACTIV™ (ORITAVANCIN FOR INJECTION) FOR INTRAVENOUS USE

Directions

Administer 1,200mg as a single dose by intravenous infusion over 3 hours

Other: _____

Quantity

vial(s)

Refills

Prescribing HCP Signature
Required

X _____
Authorizing HCP's original signature (no stamped signatures)

_____ Date

PATIENT, AUTHORIZED CAREGIVER, or AUTHORIZING HEALTHCARE PROVIDER PAP ATTESTATION and AUTHORIZATION

I attest that the information supplied above is complete and accurate, to the best of my knowledge. The patient does not receive prescription drug coverage from any government funded healthcare program, including but not limited to Medicare, Medicaid, including managed Medicaid or Tricare. I acknowledge, or, if not the patient, I acknowledge on the patient's behalf, that CorMedix Therapeutics, Inc. may discontinue this program or change its eligibility criteria at any time and without notice, and that the ORBACTIV® Support Programs may contact me via mail, telephone, fax and e-mail regarding this enrollment request and related follow-up, and that I can revoke my consent at any time. Disclaimer: **CORMEDIX THERAPEUTICS** reserves the right to request additional documentation to confirm eligibility and may conduct an e-income verification which will include a soft credit check to determine household income.

Print Name: _____

Indicate Relationship to Patient:

Patient (self)

Authorized Caregiver

Healthcare Provider

Signature: _____

← Sign Here

_____ Date:

Complete this section only if applying for the Copay Savings Program

REQUIRED FOR COPAY SAVINGS PROGRAM

Payment will be in the form of a Virtual Debit Card (VDC) via email – Please provide HCP's email address: _____

A copy of the email will be sent to the patient. Please provide the patient's email address: _____

This email address needs to be an active email address. Please note that SPAM filters should be checked in the event they filter as SPAM. The email handle will be @amgb2b.com email address.

COPAY SAVINGS PROGRAM DISCLAIMER

Patients must be United States residents and be 18 years of age or older. The Program will cover up to \$800 of a patient's obligation, and there is no out-of-pocket minimum. Patients who pay cash or who receive prescription drug coverage through any type of government insurance or reimbursement programs, including but not limited to Medicare, Medicaid, including managed Medicaid, and Tricare are not eligible. As a condition precedent of the copayment or coinsurance support provided under this program, (e.g., copay or coinsurance amounts paid to administering providers): 1) participating patients and administering providers are obligated to inform insurance companies and third-party payors of any benefits received and the value of this program, as required by contract or otherwise; and 2) administering providers may not bill patients for any amounts received under this program. Void where prohibited by law, taxed, or restricted. Additional terms and conditions may apply. Patients enrolled in the ORBACTIV® Patient Assistance Program are not eligible. CorMedix Therapeutics may determine eligibility, monitor participation, and modify or discontinue any aspect of this Program at any time. For additional information regarding ORBACTIV®, including Important Safety Information, please see the Full Prescribing Information available at <https://orbactiv.com/>.

Thank you for contacting the ORBACTIV Support Programs. We are here to help you and your patients.

Please contact us at 1-844-ORBACTIV (1-844-546-9772), fax 1-855-886-2482,

or send written communication to:

ORBACTIV Support Program

ASPN Pharmacies, LLC

ATTN: Pharmacist in Charge

290 W. Mt. Pleasant Ave. Building 2, 4th Fl., Suite 4210

Livingston, NJ 07039

This verification of benefits is not a guarantee of payment. This verification cannot take the place of written policy information from the payer. For additional assistance please contact the ORBACTIV Support Programs at 1-844-ORBACTIV.

Confidentiality notice: The information contained in this facsimile may be confidential and legally protected. It is intended only for use of the individual named. If you are not the intended recipient, you are hereby notified that the disclosure, copying, distribution, or taking of any action in regard to the contents of this fax – except its direct delivery to the intended recipient – is strictly prohibited. If you have received this fax in error, please notify the sender immediately and destroy this document and delete from your system, if applicable.

To opt-out of receiving future faxes, please contact us at 1-844-ORBACTIV (1-844-672-2284) (phone) or 1-855-886-2482 (fax).