Once-weekly

REZZAYO™

(rezafungin for injection)

PROVIDER REQUEST FORM GUIDE

- Benefits Verifications
- Prior Authorizations
- Claims Appeals Process
- Copay Assistance
- Patient Assistance Program (PAP)

Click or scan to download a digital version of the enrollment form

Contact us for information and support:

1-866 REZZAYO (1-866-739-9296)

Hours: Monday-Friday, 8:00 AM to 8:00 PM, ET

Fax: 1-888-898-0033

Email: REZZAYO@Asembia.com

melinta therapeutics

This guide for the Healthcare Provider Request Form (Enrollment Form) for the REZZAYO Patient Support Program provides information on how to complete the form accurately for submission. Incomplete or missing information for required fields may delay results.

If you have any questions while completing the form, please contact the REZZAYO Patient Support Program at 1-866-739-9296.

HEALTHCARE PROVIDER REQUEST FORM

Phone: 1-866-REZZAYO (1-866-739-9296) **Fax:** 1-888-898-0033
Hours: Monday through Friday, 8:30 am – 8:00 pm ET

REZZAYO® Support Program
ASPN Pharmacies, LLC
ATTN: Pharmacist in Charge
290 W. Mt. Pleasant Ave.
Building 2, 4th Fl., Suite 4210
Livingston, NJ 07039

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1 SERVICES REQUESTED: Select all boxes for services requested. If requesting the PAP or Copay Savings Program, completion of all relevant sections on page 2 is required.

SERVICE(S) REQUESTED		
Check all that apply: *(NOTE: Complete and sign all relevant sections on page 2)	☐ Benefit Verification ☐ Setting of Care Research ☐ Copay Savings Program*	☐ Prior Authorization Assistance ☐ Claims Assistance ☐ Patient Assistance Program (PAP)

2 PATIENT INFORMATION: Provide the patient's full name and contact information. Provide the last 4 digits of social security number if available

PATIENT INFORMATION (Required)

Patient Name _____ Date of Birth _____ SSN/ID# (last 4 digits) _____
Phone# _____ US Resident? ☐ Yes ☐ No
Patient Address _____ City _____ State ____ Zip Code _____

3 PATIENT INSURANCE INFORMATION:

- Include the insurance policy holder's information
- If available, provide a copy of both the front and back of the insurance card(s).
- Provide secondary/supplemental insurance information if applicable.
- If the patient is uninsured, check the box.

REMINDER: Always include the Medical Benefit Information. If you would like the Pharmacy Benefit to also be verified, please include this information as well.

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 ☐

4 DIAGNOSIS AND TREATMENT INFORMATION: Include the anticipated date of service and applicable ICD-10 code(s). A list of common potential ICD-10 codes is available here: REZZAYO.com/B&Cguide. The typical turn-around time for Benefits Verification and Patient Assistance Program is 1-2 business days.

REMINDER: The provider of services is responsible for correct coding.

DIAGNOSIS and TREATMENT INFORMATION (Required)

Anticipated Date of Service _____ ICD-10 Code _____

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Patient Support Program

5 PRESCRIPTION FOR REZZAYO®: This section is required if applying for the Patient Assistance Program for uninsured patients. The quantity (number of vials) is needed for a valid prescription. Example: If patient is prescribed 4 infusions of REZZAYO® (one 400mg loading dose + 3 subsequent weekly infusions of 200mg), the Quantity would be 5 vials, Refills 0.

PRESCRIPTION FOR REZZAYO® (REZAFUNGIN FOR INJECTION) FOR INTRAVENOUS USE		
Directions	**Quantity**	**Refills**
☐ Initial 400 mg dose, followed by a 200 mg dose once weekly thereafter	_____vials	
☐ Other: _____	_____vials	

6 AUTHORIZING HEALTHCARE PROVIDER INFORMATION: Include the provider's full address. The Healthcare Provider Tax ID and NPI numbers are required to process the enrollment form.

AUTHORIZING HEALTHCARE PROVIDER INFORMATION (Required)
Healthcare Provider Name_____ Specialty _____
Healthcare Provider Address _____ City _____ State _____ Zip Code _____
Healthcare Provider Tax ID#_____ Healthcare Provider NPI# _____

7 SUPPORT PROGRAM CONTACT INFORMATION. Include the contact information for the person who should receive correspondence on this Support Program request. Include name, phone number, email, and fax number.

Support Program Contact Name _____	Contact Phone#_____
Support Program Contact Email _____	Contact Fax _____

8 PREFERRED METHOD OF CONTACT. The contact information (fax or email) in the section above will be used for program communications, based on the preferred method selected

Preferred Method of Contact
What is your preferred method to receive program communication? ☐ Fax ☐ Email (Please note: All communication is sent via fax if email is not checked)

9 TREATING SETTING OF CARE: If this is a Patient Assistance Program (PAP) request, the product will be shipped to the address listed in the treating setting of care section.

- Include complete shipping address.
- The Facility NPI# and Facility Tax ID# are required.

REMINDER: Include at least one setting of care for Benefit Verification research.

TREATING SETTING OF CARE (At least one Setting of Care is required to complete 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
Treating Facility Name _____
Facility Address_____ City _____ State _____ Zip Code _____
Phone#_____ Fax# _____ Facility NPI# _____ Facility Tax ID#_____

Instructions for the Healthcare Provider Request Form

10 ADDITIONAL SETTING OF CARE: This section is optional. Complete this section if Benefits Verification research is being requested for an additional setting of care.

ADDITIONAL SETTING OF CARE (Optional. Please complete the section below if you would like to confirm additional coverage)
Setting of Care: ☐ Hospital Inpatient ☐ Hospital Outpatient ☐ Physician's Office ☐ Infusion Center ☐ Home Infusion
Treating Facility Name _____
Facility Address _____ City _____ State _____ Zip Code _____
Phone# _____ Fax# _____ Facility NPI# _____ Facility Tax ID# _____

11 AUTHORIZING HEALTHCARE PROVIDER CERTIFICATION AND CONSENT: Non-prescribing providers or office staff can sign the form for all requests except the Patient Assistance Program. PAP requests require the prescriber's signature.

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 REZZAYO® Support Programs and I agree to allow the REZZAYO® 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 REZZAYO® 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 for 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 REZZAYO® 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. By signing below, I certify that REZZAYO® is medically necessary and is being prescribed consistent with an FDA-approved indication based on my independent clinical judgment.

Authorizing Healthcare Provider: I have read and agree to the terms detailed on this form.

Signature _____ Sign Here Date _____

Authorizing Healthcare Provider's original signature (no stamped signatures)

Please note: Page 2 of the request form is ONLY needed if requesting PAP or Copay support.

Patient Assistance Program (PAP) Overview

Assistance program for uninsured or underinsured* patients demonstrating financial need:

- Patient must meet household income requirements
- Both inpatients and outpatients may be eligible for the Patient Assistance Program
- Patient must reside in the US
- **Must have a valid prescription for an FDA approved indication**

Copay Savings Program Overview

Copay support for eligible patients with private commercial insurance†

- Up to $400 per 200 mg vial
- Up to $800 for 400 mg loading dose
- No Out of Pocket Minimum
- Patient must be 18 years of age or older and a US resident
- Patient must be treated in an outpatient setting of care
- There is no income requirement to qualify for the copay program
- **Must have a valid prescription for an FDA approved indication**

* Have no prescription drug insurance coverage or insurance policy excludes coverage for the medication (with documentation of denial despite exhausting appeal options).

† A patient will not qualify if they have a prescription drug benefit through a government program (i.e. Medicaid, Medicare, Medicare Part D, Medigap, CHAMPUS, DOD, VA, TRICARE, or any state patient or pharmaceutical assistance program). As a condition precedent of the co-payment or coinsurance support provided under this program, e.g., copay or coinsurance amounts paid to administering providers, participating patients and administering providers are obligated to inform insurance companies and third-party payers of any benefits they receive and the value of this program, as required by contract or otherwise. Void where prohibited by law, taxed, or restricted. Additional terms and conditions may apply. Patients enrolled in the REZZAYO™ PAP are not eligible. Melinta Therapeutics, LLC may determine eligibility, monitor participation, and modify or discontinue any aspect of this program at any time.

12 **REQUIRED IF APPLYING FOR PAP:** Patient's total annual household income and household size are required to determine patient's eligibility.

REQUIRED FOR PAP

Patient's Total Annual Household Income* $_____ Household Size (including patient)_____

13 **PATIENT, AUTHORIZED CAREGIVER, OR AUTHORIZING HEALTHCARE PROVIDER PAP ATTESTATION AND AUTHORIZATION:** Signature and date are required. Either the patient, authorized caregiver, or authorized healthcare provider can sign for PAP.

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 Melinta Therapeutics may discontinue this program or change its eligibility criteria at any time and without notice, and that the REZZAYO® 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: **MELINTA 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 ☐ Prescribing Clinician

Signature _____ Sign Here Date _____

14 **REQUIRED FOR COPAY SAVINGS PROGRAM: Complete this section only if requesting the Copay Savings Program.**

- Email addresses are needed for the HCP office, specifically the person who will process the Virtual Debit Card payment (may be different from the prescribing HCP).
- 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.
- After program eligibility is confirmed, you will receive communication from the program with instructions on how to submit a claim for payment under the Program (including submitting the Explanation of Benefits).

REQUIRED FOR COPAY SAVINGS PROGRAM

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

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

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.

Instructions for the Healthcare Provider Request Form

COPAY SAVINGS PROGRAM DISCLAIMER

Patients must be United States residents, be 18 years of age or older, and be treated in an outpatient setting of care. There is no income requirement to qualify for the copay program. The Program will cover up to $400 per 200mg vial ($800 for 400mg loading dose) of a patient's obligation, and there is no out of pocket minimum. Patient must be commercially insured. A patient will not qualify if they have a prescription drug benefit through a government program (i.e. Medicaid, Medicare, Medicare Part D, Medigap, CHAMPUS, DOD, VA, TRICARE, or any state patient or pharmaceutical assistance program). Void where prohibited by law, taxed, or restricted. Additional terms and conditions may apply. Patients enrolled in the REZZAYO® Patient Assistance Program are not eligible. Melinta Therapeutics may determine eligibility, monitor participation, and modify or discontinue any aspect of this Program at any time. For additional information regarding REZZAYO®, including Important Safety Information, please see the Full Prescribing Information available at https://rezzayo.com.

As a condition precedent of the co-payment 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 REZZAYO® PAP are not eligible for co-payment or co-insurance support.

Thank you for contacting the REZZAYO® Support Program. We are here to help you and your patients.
Please contact us at 1-866-REZZAYO (1-866-739-9296), Fax 1-888-898-0033,
or send written communication to:
REZZAYO® 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 REZZAYO® Support Program at 1-866-REZZAYO (1-866-739-9296).

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 1-866-739-9296 (phone) or 1-888-898-0033 (fax).

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Ways to submit an enrollment form:

- Via Fax to 1-888-898-0033
- Via email: To submit an enrollment form via email please call 1-866-739-9296 to request that the Support Program enable a secure email communication channel for this purpose
- Via secure portal: Scan the QR code to create an account for the prescriber portal and view the tutorial on how to get started

INDICATION AND USAGE

REZZAYO® (rezafungin for injection) is an echinocandin antifungal indicated in patients 18 years of age or older who have limited or no alternative options for the treatment of candidemia and invasive candidiasis. Approval of this indication is based on limited clinical safety and efficacy data.

Limitations of Use

REZZAYO® has not been studied in patients with endocarditis, osteomyelitis, and meningitis due to *Candida*.

IMPORTANT SAFETY INFORMATION

Contraindications

REZZAYO® is contraindicated in patients with known hypersensitivity to rezafungin or other echinocandins.

Warnings and Precautions

- Infusion-related Reactions: REZZAYO® may cause infusion-related reactions, including flushing, sensation of warmth, urticaria, nausea, or chest tightness. If these reactions occur, slow or pause the infusion.
- Photosensitivity: REZZAYO® may cause photosensitivity. Advise patients to use protection from sun exposure and other sources of UV radiation.
- Hepatic Adverse Reactions: Abnormalities in liver tests have been seen in clinical trial patients treated with REZZAYO®. Monitor patients who develop abnormal liver tests and evaluate patients for their risk/benefit of continuing REZZAYO® therapy.

Adverse Reactions

Most common adverse reactions (incidence ≥ 5%) are hypokalemia, pyrexia, diarrhea, anemia, vomiting, nausea, hypomagnesemia, abdominal pain, constipation, and hypophosphatemia.

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Please see accompanying Prescribing Information for REZZAYO® (rezafungin for injection)

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