

Curium Connects™ Enrollment Form for BEXLUTRY™ (Lutetium Lu 177 dotatate injection)

Please complete this form and submit to **Curium Connects** by faxing to **833-590-9685**.

The website www.curiumconnects.com is available 24/7 to enroll patients, submit or update orders, and monitor status.

Contact **Curium Connects** with any questions at **844-287-2628** Monday – Friday from 8:00 AM – 8:00 PM ET.

1. Curium Connects service offerings *

* Required field

☐	Product Order ONLY	☐	Prior Authorization assistance
☐	Benefit Investigation/Benefit Verification	☐	Appeals assistance for Payer denials
☐	Benefits Investigation/Benefit Verification ONLY	☐	Copay Assistance

Our office has already completed the following **: BI/BV ☐ Prior Authorization ☐ Appeal payer denial (1st) ☐ Appeal payer denial (2nd) ☐

2. Patient Information *

Legal First Name: _____ Last Name: _____

Date of Birth: _____ Gender: Male ☐ Female ☐ Unknown ☐ Ok to leave a detailed message? ☐ Yes ☐ No

Primary Phone: _____ ☐ Cell ☐ Home Secondary Phone: _____ ☐ Cell ☐ Home

Full Physical Address: _____

Patient's City: _____ State: _____ Zip Code: _____

Alternate Contact: Name: _____ Relationship: _____ Phone number: _____
(optional) Authorization to disclose my personal health information

Primary Diagnosis (ICD-10): _____ Secondary Diagnosis (ICD-10): _____
Diagnosis codes are required for services

3. Healthcare Insurance Information (*required for any reimbursement service offerings)

If insured, please fill out the information below or attach a copy of the front and back of the patient's insurance card(s).

☐ Patient does **NOT** have healthcare insurance or indicate an alternate form of payment. If selected, **proceed to Section 4**

Primary Insurance		Secondary Insurance	
Insurance Company		Insurance Company	
Plan Name		Plan Name	
Policy #		Policy #	
Group #		Group #	
Member ID #		Member ID #	
Phone #		Phone #	
Name of insured		Name of insured	

Patient Name: _____

PATIENT AUTHORIZATION / CONSENT INFORMATION

1. Patient Authorization/ HIPAA Consent (required)

I authorize my prescribing physician and any health insurers, plans, or programs that provide me health care benefits (collectively, "Health Plans") to disclose my past and present medical or other personal information, including information in this enrollment form, information about my treatment with BEXLUTRY and related medical conditions to Curium US LLC and its agents (collectively "Curium") for purposes related to my treatment, as further described in this Authorization. I authorize Curium to use and disclose the information for the following specific purposes: ordering, manufacturing, scheduling, delivering, and infusing BEXLUTRY; obtaining payment from my Health Plan(s); conducting reimbursement verification; applying for or making referrals for Patient Assistance Programs upon my request; providing me with treatment support services ("support services") by mail or telephone, or as permitted by law. I understand that, once my information has been disclosed to Curium, federal and state privacy laws may no longer protect it against further use or disclosure. However, Curium agrees to protect my information by using it only for the purposes authorized in this Authorization or as permitted by law. I understand that signing this Authorization is voluntary and, if I do not sign this Authorization, it will not affect my ability to obtain alternative treatments from my prescribing physician or obtain insurance or insurance benefits. I understand, however, that if I do not sign this Authorization I will not be eligible to receive PAP or Copay assistance for BEXLUTRY. I may withdraw this Authorization at any time by mailing a written request to 2250 Perimeter Park Drive, Suite 300, Morrisville, North Carolina 27560 ATTN: Curium Connects or by calling 844-287-2628. Withdrawal of this Authorization will end further uses and disclosures of my information by the parties identified in this Authorization, except to the extent those uses and disclosures have been made in reliance upon this Authorization and as permitted by applicable law. This Authorization expires one (1) year from the patient signature date on page 1 unless I withdraw it earlier. I am entitled to receive a copy of this Authorization.

2. Copay

To be eligible for the Curium Connects copay program, you must be using private or commercial insurance to cover a portion of your medication costs for BEXLUTRY including plans available through state and federal healthcare exchanges. This program is not available to individuals who use any state or federal government subsidized healthcare program to cover a portion of medication costs, such as Medicare, Medicaid, TRICARE, Department of Defense, or Veterans Administration. Patients confirm that they will not seek reimbursement from any of these programs or from pharmaceutical patient assistance foundations and accounts such as a Flexible Spending Account (FSA), Health Savings Account (HSA) or Health Reimbursement Account (HRA).

If my health coverage changes, I will call the Curium Connects program at 844-287-2628.

See full Terms & Conditions for the Curium Connects copay program at www.bexlutyhcp.com/copay-terms.

3. Patient Authorization – See authorization and HIPAA information on page 2

By signing this form, I acknowledge that I have provided accurate and complete information and understand and agree to the terms of this form. My signature certifies that I have read, understood, and agreed to the release and use of my personal information, including sensitive personal information, pursuant to the Patient Authorization & Consent on page 2 and as otherwise stated on this form.

Patient's Signature: _____ Date: _____

Patient Authorized Representative's Signature: _____ Date: _____

Authorized Representative Printed Name: _____ Relationship to Patient: _____

4. Ordering Physician and Office Information *

Patient Name: _____

Ordering Physician Name: _____

Prescriber NPI #: _____ Prescriber Tax ID #: _____ Prescriber State License #: _____

Ordering Physician's Office Full Address: _____

Ordering Physician's City: _____ State: _____ Zip Code: _____

Office Contact name: _____ Phone #: _____ Fax #: _____

Office/Site Tax ID #: _____ Office/Site NPI #: _____ Office Contact email: _____

5. Referring Physician *(if different than ordering physician)*

Referring Physician Name: _____

Referring Physician NPI #: _____ Referring Physician State License #: _____

Referring Physician's Office Address: _____

Referring Physician's City: _____ State: _____ Zip Code: _____

Office Contact name: _____ Phone #: _____ Fax #: _____

6. Infusion Administration Site Information *

☐ Hospital Outpatient

☐ Other

Infusion Administration Site Name: _____

Infusion Site Full Shipping Address: _____

Infusion Site City: _____ State: _____ Zip Code: _____

Site Contact name: _____ Phone #: _____ Fax #: _____

Infusion Site Tax ID #: _____ Infusion Site NPI #: _____

Is this site registered under Section 340B of the Public Health Service Act? ☐ No ☐ Yes

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After the Enrollment Form has been completed and is signed by both the patient and physician, please fax to Curium Connects at 833-590-9685.

Patient Name: _____

HEALTHCARE PROVIDER SERVICES & ORDER INFORMATION

7. Copay Assistance Program Information

To be eligible for the Curium Connects copay program, a patient must be using private or commercial insurance to cover a portion of their medication costs for BEXLUTRY™ including plans available through state and federal healthcare exchanges. This program is not available to individuals who use any state or federal government subsidized healthcare program to cover a portion of medication costs, such as Medicare, Medicaid, TRICARE, Department of Defense, or Veterans Administration. Patients confirm that they will not seek reimbursement from any of these programs or from pharmaceutical patient assistance foundations and accounts such as a Flexible Spending Account (FSA), Health Savings Account (HSA) or Health Reimbursement Account (HRA).

See full Terms & Conditions for the Curium Connects copay program at www.bexlutryhcp.com/copay-terms.

8. Product Order

The ordering physician must complete all of the below information for the infusions scheduled for this patient. Please ensure all four (4) infusion dates are filled in to allow for accurate inventory tracking.

The BEXLUTRY approved indication is to administer 7.4 GBq (200 mCi) every 8 weeks ($\pm$ 1 week) for a total of 4 doses.

Therapies Scheduled (Eastern Time)

Infusion	Infusion Date	Infusion Time	Product Type (Vial or Syringe)
First Infusion			
Second Infusion			
Third Infusion			
Fourth Infusion			

* The Infusion dates selected are proposed and may need to change depending on if there is inventory available for that day. A Curium Connects agent will reach out to you to confirm available inventory for the scheduled infusion dates.

9. Physician Attestation (required) - I have read and agreed to the Certification and Attestation below *

I verify the information I have provided in this enrollment form is complete and accurate to the best of my knowledge. I have obtained my patient's authorization, as indicated, to disclose his/her health information related to treatment with Curium and its designated agents to use and disclose as necessary in the provision of health services or to offer patient care and reimbursement support services.

If patient is enrolled in Curium Connects, I agree that I will not submit any third-party claims for patient cost-sharing expenses (including co-pays, deductibles and/ or co-insurance) that are covered by the Curium Connects Patients Assistance Programs. I agree that I will disclose my participation in the Patient Assistance or commercial Copay program to third-party payers as required and reimbursement will not be submitted in any form. In addition, I certify that my participation in this program is consistent with my obligations as a participating provider with any third-party payers.

Physician's Signature: _____ Date: _____

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