BILPREVDA®
(denosumab-nxxp)
injection 120 mg/1.7 mL

The Organon Access Program
ENROLLMENT FORM

09/2025

Before prescribing BILPREVDA, please read the Prescribing Information.

Phone: 855-459-9965, Fax: 1-800-915-9395 • The Organon Access Program, PO Box 2889, Columbus, OH 43216

TO GET STARTED, SIGN AND COMPLETE THE ENROLLMENT FORM AND SUBMIT ONLINE, OR PRINT AND FAX THE COMPLETED DOWNLOADABLE FORM TO 1-800-915-9395. IF REQUESTING A REFERRAL TO THE ORGANON PATIENT ASSISTANCE PROGRAM OR TRIAGING TO A SPECIALTY PHARMACY, PLEASE INCLUDE A PRESCRIPTION FOR BILPREVDA, WHICH CAN BE FOUND ON PAGE 5.

PLEASE CHECK ALL BOXES THAT APPLY AND COMPLETE THE APPROPRIATE SECTION(S) OF THE FORM

- ☐ Patient Benefits Investigation only
- ☐ Patient Benefits Investigation and/or information about the Prior Authorization or Appeals Process
- ☐ Organon Co-pay Assistance Program only
  (Select this box to proceed with reviewing your patient's eligibility for the Organon Co-pay Assistance Program only. Please note, your office will not receive patient Benefits Investigation details and/or information about the Prior Authorization or Appeals Process.)
- ☐ Organon Co-pay Assistance Program
  (By selecting this box, your office will receive patient Benefits Investigation details and/or information about the Prior Authorization or Appeals Process.)
- ☐ Referral to the Organon Patient Assistance Program for eligibility determination (sponsored by the Organon Patient Assistance Program Inc.)
  If referring patient to the Patient Assistance Program or triaging to a Specialty Pharmacy, please complete the prescription on page 5.
- ☐ Patient Assistance Program – Financial Hardship Support

Patients only need to sign page 4 if they would like Co-pay Assistance Program or Patient Assistance Program support. HCPs will need to sign page 6 for all support options.

PATIENT INFORMATION SECTION

PATIENT INFORMATION

*Required fields are marked with an asterisk (*)

Patient is a US resident* **Yes** ☐ **No** ☐

Patient name*:_____ Date of birth*:_____ Sex: M ☐ F ☐

Address*:_____ City/state/zip*:_____
(Street address only, no PO boxes)

Phone*:_____ ☐ Check this box if this is a cell phone.

Email:_____

INSURANCE INFORMATION

PLEASE COMPLETE ALL THAT APPLY AND INCLUDE A FRONT AND BACK COPY OF INSURANCE CARD FOR EACH TYPE OF INSURANCE

☐ **Patient Has No Insurance** **Patient Has Insurance Through Medicare*:** ☐ **Yes** ☐ **No**

(If Yes) ☐ **Part A** ☐ **Part B** ☐ **Part D** ☐ **Medicare Advantage**

Primary insurer (including Medicaid, Medicare, veterans benefits, and private insurers)

Plan name and state*: _____

Phone number for customer service*:_____ Name of policyholder*:_____

Policyholder date of birth:_____ Policyholder relation to patient: _____

Group no.:_____ Policy ID no.*:_____

Secondary/supplemental insurer

Plan name and state: _____

Phone number for customer service:_____ Name of policyholder:_____

Policyholder date of birth:_____ Policyholder relation to patient:_____

Group no.:_____ Policy ID no.:_____

REQUIRED FOR THE ORGANON PATIENT ASSISTANCE PROGRAM

Current annual gross household income (parent/guardian if patient is under age 18): $_____ Number of household members (including patient):_____

(Please include: before-tax wages, pension, interest/dividends, Social Security benefits, and any other sources of income.)

Patient name:_____

PATIENT INFORMATION SECTION

PATIENT AUTHORIZATION

I authorize my health care provider(s) to disclose my data for The Organon Access Program, sponsored by Organon LLC, a subsidiary of Organon & Co. ("Organon"), or receive assistance from the Organon Patient Assistance Program ("Organon PAP"), sponsored by the Organon Patient Assistance Program Inc. (individually, "a Program"; collectively, "the Programs"). I understand that before I may have communications with the Programs, the administrators of the Programs, its affiliates, contractors and other third parties providing services related to these programs (collectively, "Program Administrators"), will need to obtain, review, use, and disclose my personal health information ("PHI"), including information relating to my medical condition and prescription medications and the information disclosed in this patient enrollment form.

I therefore authorize each of my physicians, pharmacies, and health plans to disclose my PHI, as necessary, to the Program Administrators so they may do the following:

- Verify my eligibility to enroll in the Programs and enroll me in the Programs for which I am eligible; and to provide me with reimbursement support and to investigate my insurance coverage in connection with The Organon Access Program.
- Use my PHI to provide the services described in this enrollment form, including to communicate Program related content by US postal mail, telephone, text, or email.
- Prepare summaries that do not include my PHI for statistical purposes.
- Share my PHI to one another and with my physicians and pharmacists as well as to Medicare, my health plans, and their administrators, contractors, or representatives, in order for them to coordinate my benefits, to provide, when applicable, reimbursement support, and to investigate my insurance coverage.
- Disclose my PHI to authorized representatives of Organon as necessary to ensure compliance with the rules of the Programs and communicate with the Program Administrators, my physicians, pharmacies, and me for compliance purposes. If I have designated a Personal Representative, to use and disclose my PHI in communicating with such Personal Representative for the purpose of verifying the information I have provided in this form and/or coordinating the provision of benefits that may be available to me under the Programs.

I understand that the PHI disclosed pursuant to this authorization, once disclosed, may not be governed by federal privacy law and may be subject to re-disclosure, but I also understand that the administrators of the Programs and their contractors and other representatives intend to use and disclose my PHI only for the purposes described in this authorization or as required by law. I further understand that if I choose not to provide this authorization, it will not affect my eligibility for, or receipt of, treatment, including Organon products, or health care insurance benefits, but I will not be able to receive any assistance from the Programs for which I may be eligible.

I understand that I may cancel this authorization at any time by telephoning The Organon Access Program at 855-459-9965 or by mailing a written request for cancellation to The Organon Access Program, PO Box 2889, Columbus, OH 43216.

I understand that canceling my authorization will mean that my physicians, pharmacies, and health plans, as well as the Programs and Program Administrators, may no longer rely on this authorization to use or disclose my PHI, but that any use or disclosure of such information that occurs before my cancellation is received will be unaffected by my cancellation.

I understand that if I do not cancel this authorization, the authorization will expire 3 years from the date of signature (or the maximum period allowed by applicable state law, if less than 3 years). For Maryland HCPs, this authorization expires one year from the date of signature. The Program Administrators will retain the information I have submitted in accordance with Organon's 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.

By signing, I certify that I have read and agree to the above Patient Authorization based on the support I have requested.

PATIENT SIGNATURE

Signature of patient, parent, legal guardian, or legal representative:_____ **Date:**_____

Name of signing party (please print):_____

Relationship to patient (if other than patient signing):_____

MARKETING COMMUNICATION CONSENT

☐ I consent to receive marketing calls and texts from and on behalf of The Organon Access Program, made with an autodialed or prerecorded voice, 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.

View our privacy policy at https://www.organon.com/privacy/

THE ORGANON CO-PAY ASSISTANCE PROGRAM TERMS AND CONDITIONS

The Organon Co-pay Assistance Program ("Co-pay Assistance Program") for BILPREVDA® (denosumab-nxxp) injection 120 mg/1.7 mL applies to claims that are submitted by a patient's health care provider ("Medical Benefit") and purchases by a patient at a participating pharmacy ("Pharmacy Benefit"). General Terms and Conditions apply to both the Medical Benefit and the Pharmacy Benefit. Below the General Terms and Conditions, you will find Specific Terms and Conditions for the Medical Benefit and Specific Terms and Conditions for the Pharmacy Benefit.

General Terms and Conditions

- To receive benefits under the Organon Co-pay Assistance Program ("Co-pay Assistance Program") for BILPREVDA ("Program Product") the patient must enroll in the Co-pay Assistance Program and be accepted as eligible.
- Patient must be prescribed the Program Product for an FDA-approved indication.
- Patient must have private health insurance that provides coverage for the cost of the Program Product under a medical benefit plan (for the Medical Benefit) or when purchased by the patient at an eligible participating pharmacy (for the Pharmacy Benefit).
- **The Co-pay Assistance Program is not valid for patients covered under Medicaid (including Medicaid patients enrolled in a qualified health plan purchased through a health insurance exchange [also known as a marketplace] established by a state government or the federal government), Medicare, a Medicare Part D or Medicare Advantage plan (regardless of whether a specific prescription is covered), TRICARE, CHAMPUS, Puerto Rico Government Health Insurance Plan ("Health Care Reform"), or any other state or federal medical or pharmaceutical benefit program or pharmaceutical assistance program (collectively, "Government Programs"). The Co-pay Assistance Program is not valid for uninsured patients.**
- **The Co-pay Assistance Program is void where prohibited by law, taxed, or restricted. Co-pay Assistance Program is not transferable. No substitutions are permitted.**

THE ORGANON CO-PAY ASSISTANCE PROGRAM TERMS AND CONDITIONS (*continued*)

- Patient must have an out-of-pocket cost for the Program Product and purchase or be administered the Program Product prior to the expiration date of the Co-pay Assistance Program. **Patient may pay as little as $0 per prescription and/or administration of Program Product.** The benefit available under the Co-pay Assistance Program is limited to the amount of the patient's actual out-of-pocket cost, on each prescription and/or administration, up to an annual maximum. The benefit available under the Co-pay Assistance Program is valid for the patient's out-of-pocket cost for the Program Product only. **It is not valid for any other out-of-pocket costs** (for example, office visit charges or medication administration charges) even if such costs are associated with the administration of the Program Product. The annual maximum for each eligible patient is determined by Organon in its sole discretion and may be changed at any time and for any reason. The annual maximum shall be disclosed to each patient when the patient calls into the following number: 855-459-9965. Organon will disclose the annual maximum as required by applicable law.
- Patient, pharmacist, and health care provider agree not to seek reimbursement for all or any part of the benefit received by the patient through the Co-pay Assistance Program. Patient (for both Medical Benefit and Pharmacy Benefit) and health care provider (for Medical Benefit) are 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.
- Patient must be a resident of the United States or the Commonwealth of Puerto Rico. Program Product must originate and be administered to patient in the United States or the Commonwealth of Puerto Rico.
- The Co-pay Assistance Program may apply to patient out-of-pocket costs incurred for Program Product within 180 days prior to the date patient is enrolled in the Co-pay Assistance Program, subject to annual Co-pay Assistance Program maximum and the applicable Terms and Conditions based on Program Product administration date. Patient or health care provider may contact The Organon Access Program for more information.
- All information applicable to the Co-pay Assistance Program requested on the enrollment form must be provided, and all certifications must be signed. Forms that are modified or do not contain all the necessary information will not be eligible for benefits under the Co-pay Assistance Program. No other purchase is necessary.
- **The Co-pay Assistance Program is not insurance.**
- The Co-pay Assistance Program forms may not be sold, purchased, traded, or counterfeited, and may be void if reproduced with such intent.
- The Co-pay Assistance Program benefit cannot be combined with any other co-pay assistance programs, free trial, discount, prescription savings card, or other offer.
- Organon reserves the right to rescind, revoke, or amend the Co-pay Assistance Program at any time without notice.
- Data related to patient's receipt of Co-pay Assistance Program benefits may be collected, analyzed, and shared with Organon, for market research and other purposes related to assessing co-pay assistance programs. Data shared with Organon will be aggregated and de-identified, meaning it will be combined with data related to other co-pay assistance program redemptions and will not identify patient.

Specific Terms and Conditions for the Medical Benefit:

- Claim for Program Product must be submitted by a health care provider to patient's private health insurance separately from other services and products.
- The benefit available under the Co-pay Assistance Program is limited to the amount the patient's private health insurance company indicates on the Explanation of Benefits ("EOB") that the patient is obligated to pay for the Program Product, up to an annual maximum.
- **An EOB from patient's private health insurance must be submitted within 180 days** of the date of the EOB for patient to receive co-pay assistance benefit, provided, however, that no EOB may be submitted more than **180 days** after the expiration date of the Co-pay Assistance Program. The EOB must reflect the patient's out-of-pocket cost for the Program Product and submission of the claim by the patient's health care provider for the cost of the Program Product.
- Benefits are not available through the Medical Benefit Co-Pay Assistance Program for BILPREVDA® (denosumab-nxxp) injection 120 mg/1.7 mL purchased by patient at a pharmacy. Co-pay assistance may be available from Organon for BILPREVDA purchased by patient at a pharmacy through the Pharmacy Benefit Co-pay Assistance Program, provided, however, that the per-patient annual maximum Co-pay Assistance Program benefit for BILPREVDA under the General Terms and Conditions has not been exceeded.

Specific Terms and Conditions for the Pharmacy Benefit:

- The Pharmacy Benefit Co-pay Assistance Program is not available for BILPREVDA if a claim was submitted by a health care provider to a patient's private health insurance company as that claim would be included in the Medical Benefit Co-pay Assistance Program.
- Benefits are not available through the Pharmacy Benefit Co-pay Assistance Program for BILPREVDA purchased by patient at a pharmacy. Co-pay assistance may be available from Organon for BILPREVDA purchased by patient at a pharmacy through the Medical Benefit Co-pay Assistance Program, provided, however, that the per-patient annual maximum Co-pay Assistance Program benefit for BILPREVDA under the General Terms and Conditions has not been exceeded.
- **Before prescribing BILPREVDA, please read the Prescribing Information.**

PATIENT CERTIFICATION: THE ORGANON CO-PAY ASSISTANCE PROGRAM

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.

I understand that I am responsible for reporting receipt of Co-pay Assistance

Patient name:_____

PATIENT INFORMATION SECTION

PATIENT CERTIFICATION: THE ORGANON CO-PAY ASSISTANCE PROGRAM (*continued*)

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 agree not to seek reimbursement for all or any part of the benefit I receive through the Co-pay Assistance Program.

I understand that co-pay assistance for any administration of Program Product to me is subject to the Co-pay Assistance Program Terms and Conditions.

MEDICAL BENEFIT ONLY: I understand that my health care provider/health care provider's office will submit a claim to my private insurance company for the Program Product administered to me. I understand that any benefit I am eligible for under the Co-pay Assistance Program may be paid directly to my health care provider/health care provider's office, on my behalf, or, if I have already paid my share of the cost of the Program Product, may be paid directly to me. I may choose to authorize my health care provider to submit the Explanation of Benefits received from my private insurance company to the Co-pay Assistance Program and to receive, on my behalf, any benefit for which I am eligible under the Program. I understand that my health care provider/health care provider's office will apply any amounts received from the Co-pay Assistance Program toward the satisfaction of my obligation for the cost of the Program Product only. I understand that I am responsible to pay my health care provider/health care provider's office the amount I owe per administration of Program Product consistent with the applicable Terms and Conditions of the Co-pay Assistance Program, and any balance owed to my health care provider/health care provider's office not covered by the Co-pay Assistance Program. If I have already paid my share of the cost of the Program Product, I will seek the amount of the benefit paid on my behalf from the Co-pay Assistance Program back from my health care provider/health care provider's office. Alternatively, if I have already paid my health care provider for my share of the cost of the Program Product, I may submit to the Co-pay Assistance Program the Explanation of Benefits I (or my health care provider) received from my private insurance company indicating the amount I am obligated to pay for the cost of the Program Product, along with all required documentation, including an invoice from my health care provider's office and a receipt reflecting the amount I paid my health care provider for the cost of the Program Product. I understand that the Co-pay Assistance Program will deny any claim for Co-pay Assistance for which inadequate, illegible, or unclear documentation has been received. I understand that any benefit for which I am eligible under the Co-pay Assistance Program will be paid only one time, either to my health care provider on my behalf or directly to me.

I understand that I am free to switch health care providers at any time without affecting my eligibility to receive benefits under the Co-pay Assistance Program, provided, however, that my new health care provider must complete the information required on the form, including the Health Care Provider Certification, before any Co-pay Assistance Program benefit for which I am eligible may be paid to such health care provider/health care provider's office on my behalf.

PHARMACY BENEFIT ONLY: I understand that if I am eligible, the Co-pay Assistance Program will mail me a coupon that I can use at an eligible participating pharmacy to receive Co-pay Assistance Program benefits.

I will inform the Co-pay Assistance Program immediately in the event I become ineligible to receive benefits under the Co-pay Assistance Program Terms and Conditions or if my insurance changes.

THE ORGANON PATIENT ASSISTANCE PROGRAM

I certify that all of the information provided in this application, including information about household income, is complete and accurate.

I understand that Organon PAP assistance will terminate if the Organon PAP becomes aware of any fraud or if this medication is no longer prescribed for me. I understand that completing this application does not ensure that I will qualify for patient assistance. I certify that I will not seek reimbursement or credit for this prescription from any insurer, health plan, or government program. If I am a member of a Medicare Part D plan, I will not seek to have the prescription or any cost associated with it counted as part of my out-of-pocket cost for prescription drugs.

I understand that Organon PAP reserves the right to modify the application form, modify or discontinue this Program, or terminate assistance at any time and without notice. I authorize Organon PAP and its affiliates to forward the prescription to a dispensing pharmacy on my behalf. Organon PAP is not acting as a dispensing pharmacy. Organon PAP is not responsible for verifying any information contained in the prescription forwarded as part of the enrollment process, including, without limitation, allergies, medical conditions, or other medications being taken by me.

I understand that I will notify the Organon PAP immediately if anything changes with my prescription, income, or my insurance coverage.

I understand that the Organon PAP reserves the right to request documentation to verify the information provided in this application for purposes of determining my eligibility for assistance, and to conduct periodic audits of my enrollment, including the health care provider who will be supervising my treatment, to verify the information provided herein.

I understand that assistance received through the Organon Patient Assistance Program is not insurance.

I understand that patients with commercial insurance are not eligible to enroll in Organon PAP.

I understand that if I have Medicare coverage, my eligibility may expire on December 31st of the current calendar year and the Organon PAP will conduct a benefit verification to confirm my eligibility and automatic enrollment for the following calendar year if I wish to continue participating in the Organon PAP.

By signing, I certify that I have read and agree to the above Patient Certification and the Terms and Conditions of the Organon Co-pay Assistance Program and the Organon Patient Assistance Program based on the support I have requested. By signing, I also certify that all information that I have provided in this application is complete and accurate.

PATIENT SIGNATURE

Signature of patient, parent, legal guardian, or legal representative: _____ **Date:** _____

Name of signing party (please print): _____

Relationship to patient (if other than patient signing): _____

STOP **Have you completed and filled out all of the required information and signed and dated directly above?**

Patient name:_____

HEALTH CARE PROVIDER INFORMATION SECTION

HEALTH CARE PROVIDER INFORMATION (to be completed by health care provider)

*Required fields are marked with an asterisk (*)

Health care provider name*:_____

Health care provider designation (MD, DO, NP, PA, Other):_____

Health care provider tax ID no.:_____

Health care provider NPI no.*:_____
(NPI must match the HCP signature on page 6)

Health care provider State license no.:_____

Health care provider State license no. expiration date: _____

Address*:_____
(Street address only, no PO boxes)

City/state/zip*:_____

Phone*:_____ Fax*:_____

Office contact person:_____

Office contact number:_____ Ext.:_____

Office email: _____

Practice/Facility name:_____

Practice tax ID no.:_____

Practice NPI no.:_____

Practice/Facility address:_____
(Street address only, no PO boxes)

City/state/zip:_____

Use is consistent with labeled indications*: Yes ☐ No ☐

For pediatric patients: I confirm closure of at least one epiphyseal growth plate (eg, humerus), verified by imaging and/or clinical assessment. Yes ☐ No ☐

Please list all applicable diagnosis codes*:

_____

_____

Next treatment date:_____

Site of Care: ☐ **Hospital outpatient department**
☐ **Health care provider office**
☐ **Other:**_____

Access preference: ☐ **Specialty Pharmacy** ☐ **Buy and Bill**

PRESCRIPTION INFORMATION

PATIENT FIRST NAME: _____ **PATIENT LAST NAME:** _____

PATIENT DATE OF BIRTH: _____

Medication	Strength	Dosage and Strength	Quantity/Refills
BILPREVDA® (denosumab-nxxp) injection 120 mg/1.7 mL	120 mg/ 1.7 mL	**Initial dose:** ☐ 1 x 120 mg subcutaneous injection ☐ 1 x 120 mg subcutaneous injection on day 1 with additional 1 x 120 mg subcutaneous injections on days 8 and 15 of first month of therapy	Quantity: ____
		Maintenance dose: ☐ 1 x 120 mg subcutaneous injection every 4 weeks	Quantity: ____ Refills: ____

☐ **Dispense as written**

Prescriber signature: _____ Date: _____

Patient name:_____

HEALTH CARE PROVIDER INFORMATION SECTION

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 BILPREVDA® (denosumab-nxxp) injection 120 mg/1.7 mL.
- 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 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 signature:_____ **Date:**_____

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 844-674-3200.

STOP **Have you completed and filled out all of the required information and signed and dated directly above?**

ORGANON