Eliquis 360 Support

Welcome to the ELIQUIS 360 Support Program

A resource guide for healthcare providers

Working Together for Patient Access to ELIQUIS

Eliquis®
(apixaban) tablets 5mg 2.5mg

Please click here for U.S. Full Prescribing Information, including **Boxed WARNINGS.**

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Introducing the ELIQUIS 360 Support Program

ELIQUIS 360 Support is a savings, access, and benefits verification assistance program for patients prescribed ELIQUIS and their providers. **We help by offering:**

- Free trial offer activation and co-pay assistance for eligible patients*
- Access and benefits verification support
- Live specialists available Monday-Friday, 8 AM to 8 PM ET, for one-on-one assistance

*Please click here for **Full Eligibility Requirements** and **Terms and Conditions.**

Please click here for U.S. Full Prescribing Information, including **Boxed WARNINGS.**

Start a Benefits Review in 3 Steps

STEP 1: Complete the Benefits Review Form for ELIQUIS. This can be downloaded from the RESOURCES page at **hcp.ELIQUIS.com** or from the ELIQUIS 360 Support Provider Portal. You can also obtain printed copies of the form from your ELIQUIS representative.

STEP 2: Have your patient review and sign the Patient Authorization and Agreement (PAA) portion of the form. The PAA can also be signed at **ELIQUIS.com/sign**.

STEP 3: Fax the completed Benefits Review Form to ELIQUIS 360 Support at **1-855-674-8134** or upload it to the ELIQUIS 360 Support Provider Portal.

After the steps above have been completed and we receive your patient's form, we will contact the patient's prescription drug plan (also referred to as the payer) to obtain coverage information and share the results with your office. You will receive a Benefits Review Results Form (also known as a Summary of Benefits) which will provide a detailed explanation of your patient's prescription insurance coverage for ELIQUIS.

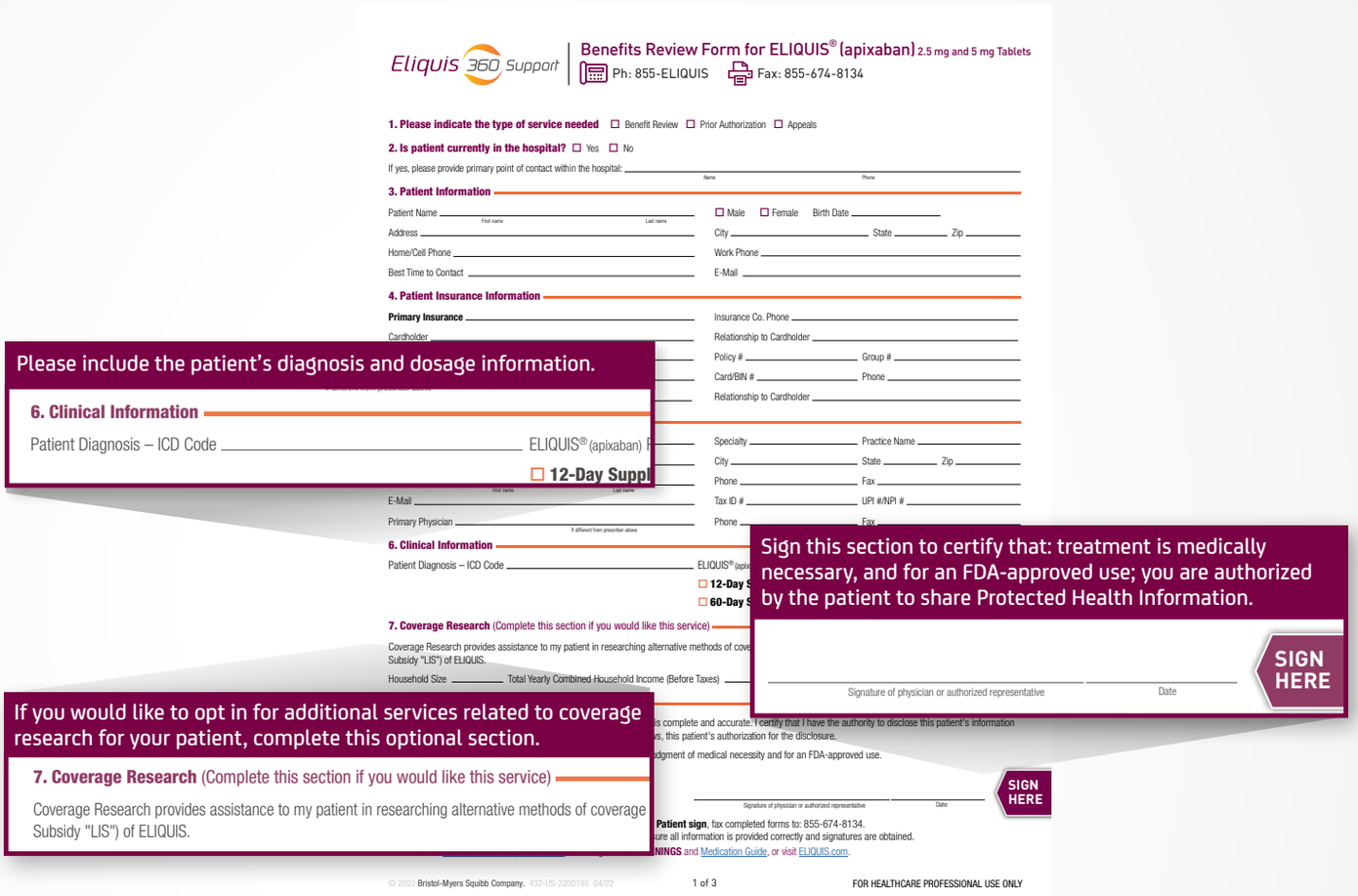
Benefits reviews are generally completed within 1 business day. Hospital benefits reviews are completed in 4-6 hours.

If there are formulary restrictions:

- A plan-specific prior authorization (PA) form will be sent to your office and pre-populated with provider demographic information
- Your office should complete the plan-specific form and send it back to the payer
- ELIQUIS 360 Support will help your office monitor progress on reviews

Benefits Review Form Guide

Please make sure that you and your patient accurately fill out the Benefits Review Form. Missed fields or signatures may cause a delay in processing results. Please pay special attention to the following:



FOR HEALTHCARE PROVIDER USE ONLY

IMPORTANT: Please review the Patient Authorization and Agreement (PAA) portion of the Benefits Review Form with your patient. The PAA can be signed at **ELIQUIS.com/sign** or a hard copy can be downloaded from the RESOURCES page at **hcp.ELIQUIS.com**. **NOTE: Patient must read, sign, date, and receive a copy of the PAA.**

Fax completed forms to **1-855-674-8134** or submit via the ELIQUIS 360 Support portal. We'll complete the benefits review and fax the results to your office.

Please click here for U.S. Full Prescribing Information, including **Boxed WARNINGS.**

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Eliquis 360 Support

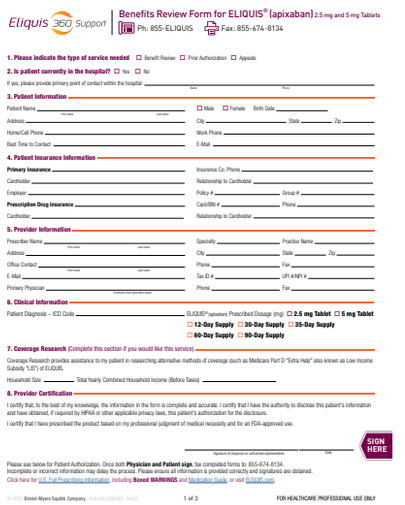
Benefits Review Form for ELIQUIS and PAA

A printed copy of the ELIQUIS 360 Support Benefits Review Form and Patient Authorization and Agreement (PAA) can be found in the Benefits Review Carrier available through your ELIQUIS representative. You can also download a copy of the form here or, if you're registered to use the ELIQUIS 360 Support Provider Portal, at **ELIQUIS360providerportal.com**.

Please see below for a closer look at the Benefits Review Form and PAA.

Benefits Review Form

Click to Enlarge



Eliquis 360 Support | Benefits Review Form for ELIQUIS® (apixaban) 2.5 mg and 5 mg Tablets

Ph: 855-ELIQUIS Fax: 855-674-8134

1. Please indicate the type of service needed ☐ Benefit Review ☐ Prior Authorization ☐ Appeals

2. Is patient currently in the hospital? ☐ Yes ☐ No

If yes, please provide primary point of contact within the hospital: _____ Name _____ Phone

3. Patient Information

Patient Name _____ ☐ Male ☐ Female Birth Date _____

Address _____ City _____ State _____ Zip _____

Home/Cell Phone _____ Work Phone _____

Best Time to Contact _____ E-Mail _____

4. Patient Insurance Information

Primary Insurance _____ Insurance Co. Phone _____

Cardholder _____ Relationship to Cardholder _____

Employer _____ Policy # _____ Group # _____

Prescription Drug Insurance _____ Card/RX# _____ Phone _____

Cardholder _____ Relationship to Cardholder _____

5. Provider Information

Prescriber Name _____ Specialty _____ Practice Name _____

Address _____ City _____ State _____ Zip _____

Office Contact _____ Phone _____ Fax _____

E-Mail _____ Tax ID # _____ UPI # NPI # _____

Primary Physician _____ Phone _____ Fax _____

6. Clinical Information

Patient Diagnosis – ICD Code _____ ELIQUIS® (apixaban) Prescribed Dosage (mg): ☐ **2.5 mg Tablet** ☐ **5 mg Tablet**

☐ **12-Day Supply** ☐ **30-Day Supply** ☐ **35-Day Supply**

☐ **60-Day Supply** ☐ **90-Day Supply**

7. Coverage Research (Complete this section if you would like this service)

Coverage Research provides assistance to my patient in researching alternative methods of coverage (such as Medicare Part D "Extra Help" also known as Low Income Subsidy "LIS") of ELIQUIS.

Household Size _____ Total Yearly Combined Household Income (Before Taxes) _____

8. Provider Certification

I certify that, to the best of my knowledge, the information in the form is complete and accurate. I certify that I have the authority to disclose this patient's information and have obtained, if required by HIPAA or other applicable privacy laws, this patient's authorization for the disclosure.

I certify that I have prescribed the product based on my professional judgment of medical necessity and for an FDA-approved use.

_____ _____

Signature of physician or authorized representative Date

SIGN HERE

Please see below for Patient Authorization. Once both **Physician and Patient sign**, fax completed forms to: 855-674-8134.
Incomplete or incorrect information may delay the process. Please ensure all information is provided correctly and signatures are obtained.
Click here for U.S. Full Prescribing Information, including **Boxed WARNINGS** and Medication Guide, or visit ELIQUIS.com.

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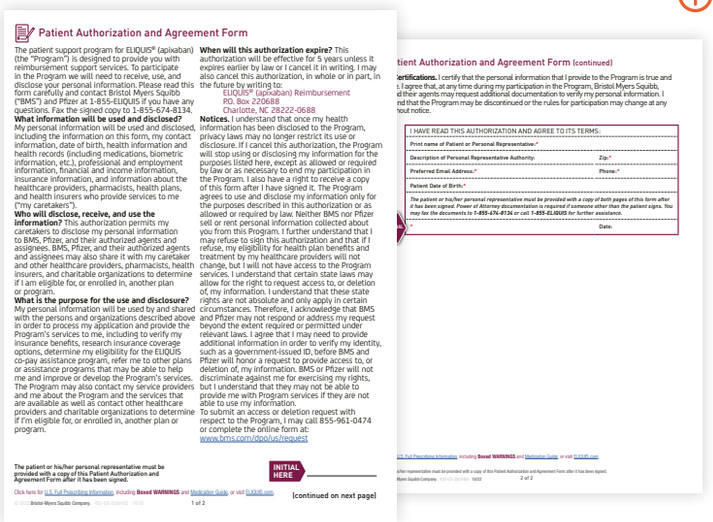
Patient Authorization and Agreement

Click to Enlarge



Patient Authorization and Agreement Form

The patient support program for ELIQUIS® (apixaban) (the "Program") is designed to provide you with reimbursement support services. To participate in the Program we will need to receive, use, and disclose your personal information. Please read this form carefully and contact Bristol Myers Squibb ("BMS") and Pfizer at 1-855-ELIQUIS if you have any questions. Fax the signed copy to 1-855-674-8134.

What information will be used and disclosed? My personal information will be used and disclosed, including the information on this form, my contact information, date of birth, health information and health records (including medications, biometric information, etc.), professional and employment information, financial and income information, insurance information, and information about the healthcare providers, pharmacists, health plans, and health insurers who provide services to me ("my caretakers").

Who will disclose, receive, and use the information? This authorization permits my caretakers to disclose my personal information to BMS, Pfizer, and their authorized agents and assignees. BMS, Pfizer, and their authorized agents and assignees may also share it with my caretaker and other healthcare providers, pharmacists, health insurers, and charitable organizations to determine if I am eligible for, or enrolled in, another plan or program.

What is the purpose for the use and disclosure? My personal information will be used by and shared with the persons and organizations described above in order to process my application and provide the Program's services to me, including to verify my insurance benefits, research insurance coverage options, determine my eligibility for the ELIQUIS co-pay assistance program, refer me to other plans or assistance programs that may be able to help me and improve or develop the Program's services. The Program may also contact my service providers and me about the Program and the services that are available as well as contact other healthcare providers and charitable organizations to determine if I'm eligible for, or enrolled in, another plan or program.

When will this authorization expire? This authorization will be effective for 5 years unless it expires earlier by law or I cancel it in writing. I may also cancel this authorization, in whole or in part, in the future by writing to:

ELIQUIS® (apixaban) Reimbursement
P.O. Box 220688
Charlotte, NC 28222-0688

Notices. I understand that once my health information has been disclosed to the Program, privacy laws may no longer restrict its use or disclosure. If I cancel this authorization, the Program will stop using or disclosing my information for the purposes listed here, except as allowed or required by law or as necessary to end my participation in the Program. I also have a right to receive a copy of this form after I have signed it. The Program agrees to use and disclose my information only for the purposes described in this authorization or as allowed or required by law. Neither BMS nor Pfizer sell or rent personal information collected about you from this Program. I further understand that I may refuse to sign this authorization and that if I refuse, my eligibility for health plan benefits and treatment by my healthcare providers will not change, but I will not have access to the Program services. I understand that certain state laws may allow for the right to request access to, or deletion of, my information. I understand that these state rights are not absolute and only apply in certain circumstances. Therefore, I acknowledge that BMS and Pfizer may not respond or address my request beyond the extent required or permitted under relevant laws. I agree that I may need to provide additional information in order to verify my identity, such as a government-issued ID, before BMS and Pfizer will honor a request to provide access to, or deletion of, my information. BMS or Pfizer will not discriminate against me for exercising my rights, but I understand that they may not be able to provide me with Program services if they are not able to use my information.

To submit an access or deletion request with respect to the Program, I may call 855-961-0474 or complete the online form at: www.bms.com/sbpolus/request

The patient or his/her personal representative must be provided with a copy of this Patient Authorization and Agreement Form after it has been signed.

INITIAL HERE _____

Click here for U.S. Full Prescribing Information, including **Boxed WARNINGS** and Medication Guide, or visit ELIQUIS.com.

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[continued on next page]

Patient Authorization and Agreement Form (continued)

Certifications. I certify that the personal information that I provide to the Program is true and I agree that, at any time during my participation in the Program, Bristol Myers Squibb, and their agents may request additional documentation to verify my personal information. I understand that the Program may be discontinued or the rules for participation may change at any time without notice.

I HAVE READ THIS AUTHORIZATION AND AGREE TO ITS TERMS:

Print name of Patient or Personal Representative:*

Description of Personal Representative Authority: Zip:*

Preferred Email Address:* Phone:*

Patient Date of Birth:*

The patient or his/her personal representative must be provided with a copy of both pages of this form after it has been signed. Power of Attorney documentation is required if someone other than the patient signs. You may fax the documents to 1-855-674-8134 or call 1-855-ELIQUIS for further assistance.

_____ Date:

U.S. Full Prescribing Information, including **Boxed WARNINGS** and Medication Guide, or visit ELIQUIS.com.

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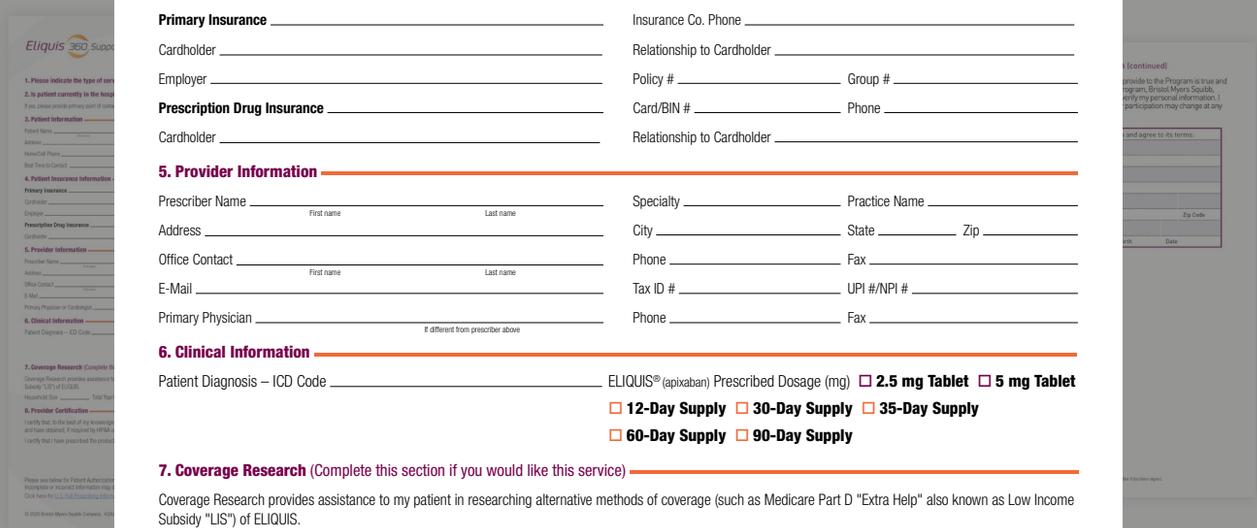
Eliquis 360 Support

Benefits Review Form for ELIQUIS and PAA



Eliquis 360 Support

Benefits Review Form for ELIQUIS® (apixaban) 2.5 mg and 5 mg Tablets

Ph: 855-ELIQUIS Fax: 855-674-8134

1. Please indicate the type of service needed ☐ Benefit Review ☐ Prior Authorization ☐ Appeals

2. Is patient currently in the hospital? ☐ Yes ☐ No

If yes, please provide primary point of contact within the hospital: _____ (Name) _____ (Phone)

3. Patient Information

Patient Name _____ (First name) _____ (Last name) ☐ Male ☐ Female Birth Date _____

Address _____ City _____ State _____ Zip _____

Home/Cell Phone _____ Work Phone _____

Best Time to Contact _____ E-Mail _____

4. Patient Insurance Information

Primary Insurance _____ Insurance Co. Phone _____

Cardholder _____ Relationship to Cardholder _____

Employer _____ Policy # _____ Group # _____

Prescription Drug Insurance _____ Card/BIN # _____ Phone _____

Cardholder _____ Relationship to Cardholder _____

5. Provider Information

Prescriber Name _____ (First name) _____ (Last name) Specialty _____ Practice Name _____

Address _____ City _____ State _____ Zip _____

Office Contact _____ (First name) _____ (Last name) Phone _____ Fax _____

E-Mail _____ Tax ID # _____ UPI #/NPI # _____

Primary Physician _____ (If different from prescriber above) Phone _____ Fax _____

6. Clinical Information

Patient Diagnosis – ICD Code _____ ELIQUIS® (apixaban) Prescribed Dosage (mg) ☐ **2.5 mg Tablet** ☐ **5 mg Tablet**

☐ **12-Day Supply** ☐ **30-Day Supply** ☐ **35-Day Supply**

☐ **60-Day Supply** ☐ **90-Day Supply**

7. Coverage Research (Complete this section if you would like this service)

Coverage Research provides assistance to my patient in researching alternative methods of coverage (such as Medicare Part D "Extra Help" also known as Low Income Subsidy "LIS") of ELIQUIS.

Household Size _____ Total Yearly Combined Household Income (Before Taxes) _____

8. Provider Certification

I certify that, to the best of my knowledge, the information in the form is complete and accurate. I certify that I have the authority to disclose this patient's information and have obtained, if required by HIPAA or other applicable privacy laws, this patient's authorization for the disclosure.

I certify that I have prescribed the product based on my professional judgment of medical necessity and for an FDA-approved use.

_____ (Signature of physician or authorized representative) _____ (Date)

SIGN HERE

Please see below for Patient Authorization. Once both **Physician and Patient sign**, fax completed forms to: 855-674-8134.
Incomplete or incorrect information may delay the process. Please ensure all information is provided correctly and signatures are obtained.

Click here for U.S. Full Prescribing Information, including **Boxed WARNINGS** and Medication Guide, or visit ELIQUIS.com.

FOR HEALTHCARE PROFESSIONAL USE ONLY

Please click here for U.S. Full Prescribing Information, including **Boxed WARNINGS.**

Eliquis® (apixaban) tablets 5mg 2.5mg

Eliquis 360 Support

Benefits Review Form for ELIQUIS and PAA

A printed copy of the ELIQUIS 360 Support Benefits Review Form and Patient Authorization and Agreement (PAA) can be found in the Benefits Review Carrier available through your ELIQUIS m here or, if you're registered to use the

Patient Authorization and Agreement Form

The patient support program for ELIQUIS® (apixaban) (the "Program") is designed to provide you with reimbursement support services. To participate in the Program we will need to receive, use, and disclose your personal information. Please read this form carefully and contact Bristol Myers Squibb ("BMS") and Pfizer at 1-855-ELIQUIS if you have any questions. Fax the signed copy to 1-855-674-8134.

What information will be used and disclosed? My personal information will be used and disclosed, including the information on this form, my contact information, date of birth, health information and health records (including medications, biometric information, etc.), professional and employment information, financial and income information, insurance information, and information about the healthcare providers, pharmacists, health plans, and health insurers who provide services to me ("my caretakers").

Who will disclose, receive, and use the information? This authorization permits my caretakers to disclose my personal information to BMS, Pfizer, and their authorized agents and assignees. BMS, Pfizer, and their authorized agents and assignees may also share it with my caretaker and other healthcare providers, pharmacists, health insurers, and charitable organizations to determine if I am eligible for, or enrolled in, another plan or program.

What is the purpose for the use and disclosure? My personal information will be used by and shared with the persons and organizations described above in order to process my application and provide the Program's services to me, including to verify my insurance benefits, research insurance coverage options, determine my eligibility for the ELIQUIS co-pay assistance program, refer me to other plans or assistance programs that may be able to help me and improve or develop the Program's services. The Program may also contact my service providers and me about the Program and the services that are available as well as contact other healthcare providers and charitable organizations to determine if I'm eligible for, or enrolled in, another plan or program.

When will this authorization expire? This authorization will be effective for 5 years unless it expires earlier by law or I cancel it in writing. I may also cancel this authorization, in whole or in part, in the future by writing to:

ELIQUIS® (apixaban) Reimbursement
P.O. Box 220688
Charlotte, NC 28222-0688

Notices. I understand that once my health information has been disclosed to the Program, privacy laws may no longer restrict its use or disclosure. If I cancel this authorization, the Program will stop using or disclosing my information for the purposes listed here, except as allowed or required by law or as necessary to end my participation in the Program. I also have a right to receive a copy of this form after I have signed it. The Program agrees to use and disclose my information only for the purposes described in this authorization or as allowed or required by law. Neither BMS nor Pfizer sell or rent personal information collected about you from this Program. I further understand that I may refuse to sign this authorization and that if I refuse, my eligibility for health plan benefits and treatment by my healthcare providers will not change, but I will not have access to the Program services. I understand that certain state laws may allow for the right to request access to, or deletion of, my information. I understand that these state rights are not absolute and only apply in certain circumstances. Therefore, I acknowledge that BMS and Pfizer may not respond or address my request beyond the extent required or permitted under relevant laws. I agree that I may need to provide additional information in order to verify my identity, such as a government-issued ID, before BMS and Pfizer will honor a request to provide access to, or deletion of, my information. BMS or Pfizer will not discriminate against me for exercising my rights, but I understand that they may not be able to provide me with Program services if they are not able to use my information.

To submit an access or deletion request with respect to the Program, I may call 855-961-0474 or complete the online form at: www.bms.com/dpo/us/request

The patient or his/her personal representative must be provided with a copy of this Patient Authorization and Agreement Form after it has been signed.

INITIAL HERE _____

Click here for U.S. Full Prescribing Information, including **Boxed WARNINGS** and Medication Guide, or visit ELIQUIS.com.

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tient Authorization and Agreement Form (continued)

ertifications. I certify that the personal information that I provide to the Program is true and . I agree that, at any time during my participation in the Program, Bristol Myers Squibb, d their agents may request additional documentation to verify my personal information. I nd that the Program may be discontinued or the rules for participation may change at any hout notice.

I HAVE READ THIS AUTHORIZATION AND AGREE TO ITS TERMS:

Print name of Patient or Personal Representative:*

Description of Personal Representative Authority: **Zip:***

Preferred Email Address:* **Phone:***

Patient Date of Birth:*

The patient or his/her personal representative must be provided with a copy of both pages of this form after it has been signed. Power of Attorney documentation is required if someone other than the patient signs. You may fax the documents to 1-855-674-8134 or call 1-855-ELIQUIS for further assistance.

* **Date:**

U.S. Full Prescribing Information, including **Boxed WARNINGS** and Medication Guide, or visit ELIQUIS.com.

s/her representative must be provided with a copy of this Patient Authorization and Agreement Form after it has been signed.

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Please click here for U.S. Full Prescribing Information, including **Boxed WARNINGS.**

Eliquis® (apixaban) tablets 5mg 2.5mg

Eliquis 360 Support

SUPPORT FOR PROVIDERS

Two Ways to Submit the Benefits Review Form

Send via Fax to 1-855-674-8134

1. After completing the Benefits Review Form for ELIQUIS*, have your patient review and sign the Patient Authorization and Agreement (PAA). The PAA can also be signed at **ELIQUIS.com/sign**.
2. Fax the signed and completed form to **1-855-674-8134**.
3. You will receive confirmation of receipt within 4 hours.
4. A Benefits Review Results Form will be returned via fax within 1 business day and will include:
   - Financial responsibility and structure of benefits
   - Any applicable payer forms required
   - Instructions for what needs to be done next

Submit via the ELIQUIS 360 Support Portal

1. Log on to **ELIQUIS360providerportal.com**. If you haven't already done so, register to use the portal.
2. Click on Patient Enrollment on the toolbar. Fill out the online Benefits Review Enrollment Form.
3. Patient will review and sign the PAA via a downloaded printed copy or via eSignature. A hard copy of the signed PAA can be uploaded to the portal or faxed to **1-855-674-8134**.
4. Once submitted, your office will receive a call from an ELIQUIS 360 Support Live Specialist, as well as a fax detailing the patient's summary of benefits, within 1 business day. The benefits review results will also be visible in the Patient Documents section of the patient's profile.

*By signing this form, you are certifying that you have received authorization to release the medical and/or other patient information relating to therapy to The Lash Group, Inc. (acting as an agent for Bristol Myers Squibb and Pfizer), for the purpose of seeking benefits review in initiation or continuation of therapy and any additional services that you have not opted out of on the form. Aggregate data regarding research requests for you and others may be shared with Bristol Myers Squibb and Pfizer.

Please click here for U.S. Full Prescribing Information, including **Boxed WARNINGS.**

SUPPORT FOR PATIENTS

How Patients Can Initiate a Benefits Review

- If you've prescribed ELIQUIS for your patient and you're unable to complete the Benefits Review Form while your patient is in the office, they can start the process on their own by calling ELIQUIS 360 Support at **1-855-ELIQUIS (354-7847) Monday-Friday, 8 AM to 8 PM ET**
- Our live specialists will direct patients to **ELIQUIS.com/sign** for an electronic signature that will authorize us to conduct a benefits review
- Patients will receive a Benefits Review Results Form within 1 business day of the benefits review request. If your patient gives consent, we will provide a copy of the results to your office as well

Live Specialists* are available to speak with patients about prescription insurance coverage assistance Monday-Friday, 8 AM to 8 PM ET.

1-855-ELIQUIS (1-855-354-7847)

Card activation for eligible patients is available 24 hours a day/7 days a week.

*Includes bilingual specialists.

Please click here for U.S. Full Prescribing Information, including **Boxed WARNINGS.**

Sample Benefits Review Results - Medicare Part D

After the Benefits Review Form has been submitted, your office will receive information regarding your patient's coverage. This is an example of results you may receive for a Medicare Part D patient.

BENEFITS REVIEW RESULTS FORM FOR ELIQUIS® (apixaban)

Eliquis 360 Support

Phone: **(866) 863-7502** • Fax: **(855) 674-8134** • www.eliquis.com

$10 CO-PAY ELIGIBLE ☐YES ☒NO

PATIENT INFORMATION

NAME: Lisa Simpson | DATE OF BIRTH: 02/09/1950 | RECORD ID: NU001XCA

PROVIDER INFORMATION

PRESCRIBER: Dr. Nicholas Riviera | SITE NAME: Riviera Institute of Medicine

PRIMARY INSURANCE COVERAGE INFORMATION

PAYER NAME: United Healthcare | PAYER PHONE: 555-555-5555 | POLICY #: 987654989

PAYER TYPE: Medicare | PLAN NAME: | PLAN TYPE: Part D

POLICY EFFECTIVE DATE: <01/01/2019>

BENEFIT DETAILS

COVERAGE

☐ COVERED	DEDUCTIBLE: $415	
☒ PENDING PA	CO-PAY (30 DAY): $47	
☐ NOT COVERED	CO-PAY (90 DAY): $141	
☐ UNDISCLOSED	COINSURANCE: N/A	OUT-OF-POCKET MAX: $3820

COVERAGE DETAILS / COMMENTS: ELIQUIS: Covered
ELIQUIS Prior Authorization: Required
Deductible: $415 ($415 met)
Once deductible is met, ELIQUIS cost: 30-day retail - $47 copay and 90-day mail order - $141 up to out-of-pocket cost of $3820 ($415 met).
During Coverage Gap, ELIQUIS cost: 25% co-insurance up to total out-of-pocket cost of $5100 ($0 met). Once met, the coinsurance will be 5% for the remainder of the year.

AUTHORIZATION INFORMATION / REQUIREMENTS

PA REQUIREMENTS

☒ PA REQUIRED	AUTH #:	
☐ PA NOT REQUIRED	PHONE:	FAX:

AUTHORIZATION REQUIREMENTS: Prior Authorization (PA) is required and is not on file. To initiate PA, provider may call 800-555-1234 and provide dx code, dosage, and previously tried/failed medications. Turnaround time is 24-48 hours and notified via fax.

This document is provided for information purposes only and is not intended to provide reimbursement or legal advice. Benefit reviews completed by the ELIQUIS 360 Support Program do not guarantee payer reimbursement for product treatment and administration. The ELIQUIS 360 Support Program makes no representations or warranties, expressed or implied, as to the accuracy or completeness of the information.

If you have submitted a Benefits Review request, the results will be faxed to the contact listed on the Request Form.

If a patient is eligible for $10 co-pay card, it will be indicated here. Please note as this is for a patient without commercial coverage, they would not be eligible for the $10 co-pay card.

Detailed Benefits Review Results that clearly state if ELIQUIS is covered, as well as deductible, co-pay, co-insurance, out-of-pocket maximum, and other relevant information for each individual patient.

Detailed Benefits Review Results that clearly state if a Prior Authorization is needed as well as the requirements for getting Prior Authorization based on current coverage.

Please click here for U.S. Full Prescribing Information, including **Boxed WARNINGS.**

Sample Benefits Review Results - Private Commercial Insurance

After the Benefits Review Form has been submitted, your office will receive information regarding your patient's coverage. This is an example of results you may receive for a commercially insured patient.

BENEFITS REVIEW RESULTS FORM FOR ELIQUIS® (apixaban)

Eliquis 360 Support

Phone: **(866) 863-7502** • Fax: **(855) 674-8134** • www.eliquis.com

$10 CO-PAY ELIGIBLE ☐YES ☐NO

PATIENT INFORMATION

NAME: Homer Simpson | DATE OF BIRTH: 05/01/1975 | RECORD ID: NU001XBA

PROVIDER INFORMATION

PRESCRIBER: Dr. Nicholas Riviera | SITE NAME: Riviera Institute of Medicine

PRIMARY INSURANCE COVERAGE INFORMATION

PAYER NAME: Aetna | PAYER PHONE: 555-555-1234 | POLICY #: 987654321

PAYER TYPE: Private Commercial | PLAN NAME: | PLAN TYPE: PPO

POLICY EFFECTIVE DATE: <01/01/2019>

BENEFIT DETAILS

COVERAGE

☒ COVERED	DEDUCTIBLE: N/A	
☐ PENDING PA	CO-PAY (30 DAY): $40	
☐ NOT COVERED	CO-PAY (90 DAY): $110	
☐ UNDISCLOSED	COINSURANCE: N/A	OUT-OF-POCKET MAX: $2000

COVERAGE DETAILS / COMMENTS: ELIQUIS: Covered
ELIQUIS Prior Authorization: Not Required
Deductible: No deductible
ELIQUIS cost: 30-day retail - $40 copay and 90-day mail order - $110 copay
Patient's maximum out-of-pocket cost: $2000 ($0 met).
Your patient appears eligible for the $10 copay card.

AUTHORIZATION INFORMATION / REQUIREMENTS

PA REQUIREMENTS

☐ PA REQUIRED	AUTH #:	
☒ PA NOT REQUIRED	PHONE:	FAX:

AUTHORIZATION REQUIREMENTS:

If you have submitted a Benefits Review request, the results will be faxed to the contact listed on the Request Form.

If a patient is eligible for $10 co-pay card, it will be indicated here.

Detailed Benefits Review Results that clearly state if ELIQUIS is covered, as well as deductible, co-pay, co-insurance, out-of-pocket maximum, and other relevant information for each individual patient.

Detailed Benefits Review Results that clearly state if a Prior Authorization is needed as well as the requirements for getting Prior Authorization based on current coverage.

Please click here for U.S. Full Prescribing Information, including **Boxed WARNINGS.**

Program Resources to Assist Patients and Providers

Other helpful ELIQUIS 360 Support program resources can be found at **hcp.ELIQUIS.com** including:

- Formulary Coverage Look-Up Tool
- Information about the $10 Co-Pay Card and Free 30-Day Trial Offer
- Downloadable Benefits Review Form
- Select Patient and Physician Resources

Please click here for U.S. Full Prescribing Information, including **Boxed WARNINGS.**

Contact Information

For More Information

Call 1-855-ELIQUIS (1-855-354-7847)

OR

Visit hcp.ELIQUIS.com

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