BioLineRx Connect

PATIENT ENROLLMENT FORM

Phone: 1-866-524-6546

FAX: 1-877-256-2430

This Patient Enrollment Form is for patients who may receive APHEXDA™(motixafortide) to enroll in BioLineRx Connect, a patient support program offered by BioLineRx USA, Inc. Please complete and return this enrollment form by FAX to 1-877-256-2430. If you require assistance in completing this form or have questions about BioLineRx Connect, we can be reached Monday – Friday 9:00 AM – 5:00 PM ET at 1-866- 524-6546.

1. PATIENT INFORMATION

Patient First Name **Patient Last Name**

DOB

Email

Street Address

Gender: ☐ **Male** ☐ **Female** ☐ **Other**

Patient Preferred Language (if not English)

City **State** **Zip Code**

Phone # ☐ **Home** ☐ **Mobile**

☐ ***Check here if it is OK to leave a detailed message***

Alternate Contact Phone #

Alternate Contact Relationship to Patient

2. PATIENT INSURANCE INFORMATION - Include front and back copies of insurance cards for each type of insurance

PRIMARY INSURANCE		SECONDARY INSURANCE	
Insurance Company		Insurance Company	
Line of Business		Line of Business	
Plan Name		Plan Name	
Plan Type		Plan Type	
Policy #		Policy #	
Group #		Group #	
Member ID #		Member ID #	
Phone #		Phone #	
Policyholder Name		Policyholder Name	
Relationship to Patient		Relationship to Patient	

☐ Patient does not have insurance

3. PRESCRIBER INFORMATION

Prescriber First & Last Name

NPI # **State License #**

Office Contact Name:

Site/Facility Name

Tax ID #: **PTAN:**

Phone # **Fax #**

Site/Facility Address

Medicaid #:

Email

Preferred Method of Communication:
☐ **Phone** ☐ **Fax**

City **State** **Zip Code**

Is Prescriber contracted with patient's insurance? ☐ **Yes** ☐ **No**

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US-APH-2300058 (v 1.0) 09/2023

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4. DIAGNOSIS AND SITE OF CARE INFORMATION

Diagnosis:

☐ C90.00-C90.32 Multiple myeloma and malignant plasma cell neoplasms
☐ Z94.81 Bone marrow transplant status
☐ Z52.001 Unspecified donor, stem cells
☐ Z52.091 Other blood donor, stem cells
☐ Z94.84 Stem cells transplant status
☐ Z52.011 Autologous donor, stem cells
☐ Other ICD-10 code(s): ___________________

Site of Care (if different than Prescriber Information):

Name of site where patient will be given APHEXDA
Address (include city, state, and zip code)
NPI Number

5. SERVICES REQUESTED: Check services requested:

☐ **Benefits Investigation/Prior Authorization Investigation** ☐**Appeals/Claims Support**

6. PRESCRIBER AUTHORIZATION

By signing below, I certify that (a) APHEXDA is medically necessary, and (b) I have received from the patient identified above, or his/her authorized personal representative, the necessary authorization to release, in accordance with applicable federal and state privacy laws and regulations, referenced medical and/or other patient information relating to the need for the drug to BioLineRx USA, Inc., its authorized program service provider, its employees, affiliates and their representatives, its business partners, agents, and contractors for the purpose of seeking information related to coverage for the agent and/or related procedure.

Prescriber's Signature:	**Date:**

Please note:
BioLineRx Connect cannot accept any information without an executed Patient Authorization to Share Health Information form.

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Patient Authorization to Share Health Information

By signing this authorization, I understand I agree to the collection, disclosure and use of my personal health information, including but not limited to, name, address, social security number, telephone number, insurance information, medical condition and treatment (including prescriptions), medical records and other related information contained on this form or provided by authorized persons ("Personal Health Information"). I hereby authorize each of my doctor(s) and their staff, health plans, insurers, hospitals, clinics, pharmacies, distributors or other health care providers and those working on their behalf to disclose my Personal Health Information to BioLineRx USA, Inc., its employees, affiliates and their representatives, its business partners, agents, and contractors, in connection with the BioLineRx Connect program described to me (the "Program"). I understand that my Personal Health Information may be used for the following purposes: (i) verifying, investigating, coordinating and resolving insurance coverage or reimbursement inquiries and payment for APHEXDA; (ii) enrolling me in and contacting me about the Program, including providing me with educational materials and information, services related to my therapy or my medical condition; (iii) contacting and providing my Personal Health Information to my insurer, patient advocacy organizations, patient assistance programs, co-pay assistance or similar programs to determine eligibility for coverage and enrolling me in such programs if eligible; (iv) managing the Program; and (v) conducting market analysis or other commercial activity, or aggregating my Personal Health Information with other data for such analysis.

I understand that BioLineRx USA, Inc., through the Program, may report back to my healthcare professional(s) any Personal Health Information about me that they may create or receive.

I agree that BioLineRx USA, Inc. may contact me in the future via email, mail, and by text message or live, autodialed and/or prerecorded messages at the telephone numbers provided by me.

I understand that once my Personal Health Information is disclosed it may no longer be protected by federal or state law regarding patient privacy and it may be subject to re-disclosure without my permission. I understand that I may refuse to sign this authorization or revoke it at any time in the future, and my refusal or future revocation will not affect my treatment, payment or eligibility for benefits. This authorization will remain valid for ten (10) years after the date of my signature, unless I cancel it earlier by mailing a letter requesting such cancellation to BioLineRx Connect, 1 Tara Boulevard, Suite 200, Nashua, NH 03062 or calling 1-866-524-6546 however, revoking this authorization will not impact BioLineRx USA, Inc.'s ability to use and disclose Personal Health Information it has received prior to the cancellation. I also understand that the Program may be changed or ended at any time without prior notification. I understand that I am entitled to a copy of this Authorization.

I verify that the information provided is true and correct. If I am the caregiver for the patient, I confirm that I am authorized to sign on behalf of the patient.

☐ **I do not wish to receive any marketing materials from BioLineRx USA, Inc. related to this application**

______________________________	______________________________
Patient Name	**Date**
______________________________	______________________________
Patient or Guardian Signature	**Representative relationship to patient (e.g., spouse, legal, guardian, etc.)**

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