HEPZATO KIT™ ACCESS

HEPZATO KIT™ (melphalan) for Injection/ Hepatic Delivery System (HDS)

Enrollment Form

Please complete the form and fax with required documentation to: (888) 845-8593 or email info@hepzatokitaccess.com

Questions? Call (866) 4-HEPZATO

PATIENT INFORMATION

First Name:	Last Name:
Date of Birth:	Phone: ☐ home ☐ cell
Address:	Email:
City, State, Zip Code:	Preferred Communication: ☐ phone ☐ email ☐ text/SMS*
Product Name: HEPZATO KIT™ (melphalan) for Injection/Hepatic Delivery System	

**I opt-in to SMS/text messaging communications about any support services I choose to enroll in below.*

PATIENT INSURANCE INFORMATION

Primary Insurance Name:		Secondary Insurance Name:	
Primary Policy Number:		Secondary Policy Number:	
Primary Group Number:		Secondary Group Number:	
Policy Holder:	Date of Birth:	Policy Holder:	Date of Birth:

HEPZATO KIT ACCESS 360

The HEPZATO KIT ACCESS 360 Program is available to help you with your out-of-pocket cost for the HEPZATO KIT. Eligible individuals can receive treatment with the HEPZATO KIT for as little as $0. Maximum benefit is $10,000 per calendar year.

You may be eligible for HEPZATO KIT ACCESS 360 if you:

1. Are commercially (private or non-governmental) insured
2. Are a resident of the US, and have been or will be treated with the HEPZATO KIT at a Delcath REMS-certified facility.

HOW TO ACTIVATE HEPZATO KIT ACCESS 360

- HEPZATO KIT ACCESS 360 will confirm your eligibility upon receipt of your completed enrollment form.
- Fax enrollment form and Explanation of Benefits (EOB) to: (888) 845-8593. Explanation of Benefits (EOB) are accepted up to 120 days after your HEPZATO KIT treatment.
- Claim forms must identify HEPZATO KIT and specify costs associated with HEPZATO KIT (HCPCS Code: J9248).
- Once your claim is reviewed and approved, check(s) will be mailed to providers typically within 2 weeks.
- Follow up with your provider to confirm your new out-of-pocket costs for HEPZATO KIT.

DELCATH CLINICAL NAVIGATOR

Delcath offers a Navigator Support Program to support your treatment with HEPZATO KIT. This program is not a replacement for your medical support team but meant to be an educational and adherence resource to help answer questions throughout your treatment.

☐ I would like to enroll in the Delcath Clinical Navigator Program.

REQUIRED DOCUMENTATION

☐ Insurance Card (Front & Back)	☐ Diagnostic Reports
☐ Clinical Documentation	

Please see full Prescribing Information, including Boxed Warning.

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HIPAA Authorization

Background
Your doctor has identified you as a potential candidate for treatment with the Hepzato Kit. To assist you in determining your insurance coverage for treatment with the HEPZATO KIT, you may choose to enroll in HEPZATO KIT Access, which is administered by Delcath through its contractor, PRO-Spectus.

Scope, Use, and Disclosure of Your Health Information
If you choose to sign this Authorization, you authorize your healthcare providers, your health insurance company, including the requesting/treating providers and the facility at which you are treated, to disclose to Delcath Systems, Inc. and its respective affiliates, agents, and contracted third parties, including, but not limited to HEPZATO KIT Access (administered via PRO-Spectus), (collectively, "Companies") your protected health information ("Health Information"), for the purposes described below. This Health Information includes all of your medical records related to your possible treatment with the HEPZATO KIT, as well as information related to your treatment and insurance coverage (for example, your name, address, phone number, email address, or information about your medical condition or status).

Examples of how your information may be used and/or disclosed if you execute this Authorization, include, but are not limited to, the following:

- to enroll you in "HEPZATO KIT Access," a support resource designed to assist with questions as well as provide assistance regarding insurance;
- to help verify or coordinate insurance coverage or otherwise obtain payment for your treatment with the HEPZATO KIT;
- to provide updates regarding the status of your insurance coverage, including reasons for any insurance denial, to your healthcare provider and Delcath, specifically including Delcath's field representatives;
- to provide you with educational information related to HEPZATO KIT or similar products that may be of interest, including disease awareness and management programs;
- to provide you with support related to your HEPZATO KIT treatment.
- to communicate with your healthcare provider or you regarding the status of your HEPZATO KIT treatment;
- to conduct quality assurance, surveys, and other business activities in connection with HEPZATO KIT treatment;
- to help arrange financial assistance to help pay for my HEPZATO KIT treatment by contacting insurance, other potential funding services, social workers, patient advocacy organizations, or patient assistance programs on your behalf in order to determine if you are eligible for other financial assistance and to obtain such financial assistance; and
- to collect information related to HEPZATO KIT treatment to assist with the coordination of care, efforts to obtain reimbursement for HEPZATO KIT, and to demonstrate the safety and efficacy of HEPZATO KIT.

Authorization
I authorize the program HEPZATO KIT Access to receive and share my Health Information on my behalf and release to a payor (insurance company), pharmacy provider, and/or a treating facility.

I understand that the Companies may contact me by mail, email, text, telephone, and/or any alternative communication method ("Communications") for the purposes described in this Authorization. I understand that Delcath may pay Companies to provide some of these Communications to me.

I understand that I am not required to sign this Authorization as a condition to receive treatment with Delcath products or reimbursement for treatment; enrolling in a health plan or establishing eligibility for benefits. However, I also understand that by refusing to sign this Authorization, I will not be able to enroll in or receive certain services provided by the HEPZATO KIT Access Program. I understand that I may refuse to sign this Authorization.

I understand that I should keep a copy of the executed Authorization for my records. I understand that I may revoke this Authorization at any time by notifying Delcath in writing at the following address:

HEPZATO KIT Access
c/o Delcath Systems Inc.
566 Queensbury Ave
Queensbury, NY 12804

I understand that the revocation of this Authorization will be effective upon actual receipt of my letter by Delcath at the above address. Revoking this Authorization will end my consent to further disclosure of my Health Information to Delcath and the Companies. If I revoke this Authorization, it will not have any effect on any actions taken by the Companies before the revocation.

I understand that the Health Information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient(s), because it may no longer be protected by federal privacy regulations, including HIPAA.

This Authorization expires five (5) years from the date this Authorization is signed (unless a shorter period is required by law).

By executing this Authorization, I certify that I (1) have read this Authorization; (2) understand the Scope and Uses and Disclosure of Your Health Insurance Information; and (3) Authorize the use and disclosure of my protected health information as described above.

Patient Signature: Patient Name (print): Date:

Phone Number: Email:

Address:

COMPLETE THIS SECTION ONLY IF APPLICABLE

Personal Representative Signature: Personal Representative Name (print):

Relationship to Patient, including the authority for status as Personal Representative:

Permission to share medical information - my medical information may be obtained and exchanged verbally to:

Name: Relationship to me:

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HEPZATO KIT ACCESS 360 TERMS AND CONDITIONS

- HEPZATO KIT ACCESS 360 helps eligible patients with commercial/private insurance who have been prescribed Hepzato Kit for an FDA-approved indication and may need assistance with their out-of-pocket costs. Patients must re-enroll every calendar year.
- Eligibility requirements, program rules, and restrictions apply.
- Enrollment in HEPZATO KIT ACCESS 360 and certification of eligibility and compliance with program rules is required to participate in the Program. The assistance provided through HEPZATO KIT ACCESS 360 is not conditioned on any past, present, or future use or purchases.
- Patients enrolled in HEPZATO KIT ACCESS 360 that meet eligibility criteria may receive a maximum annual benefit up to $10,000 under the program. Patients are responsible for any costs associated with the HEPZATO KIT that exceed the maximum benefit. The total out-of-pocket cost is dependent on the patient's individual health insurance plan. Only costs associated with HEPZATO KIT are eligible.
- The patient or their guardian must be 18 years of age or older to receive assistance.
- Healthcare providers may not advertise or otherwise use HEPZATO KIT ACCESS 360 as a means of promoting their services or Delcath medicines to patients. The Program is not intended for the benefit of third parties, including without limitation third-party payers, pharmacy benefit managers, or their agents.
- HEPZATO KIT ACCESS 360 is only valid in the United States and U.S. Territories, is void where prohibited by law, and shall follow state restrictions in relation to AB-rated generic equivalents (e.g., MA, CA) where applicable.

PATIENT AUTHORIZATION AND DECLARATIONS (SIGNATURE REQUIRED FOR ENROLLMENT)

- By signing below, I authorize HEPZATO KIT ACCESS 360 to contact my health insurers and my healthcare providers to determine my eligibility for HEPZATO KIT ACCESS 360 (program). I authorize the Program to communicate with me over various means including (but not limited to) telephone, mail, sms/"Text" messaging based on my preference above.
- I understand that if I am approved for HEPZATO KIT ACCESS 360 that copay assistance funds will be distributed to the facility/hospital where I was or will be treated the HEPZATO KIT. I understand that any requests for copay assistance should be submitted within 120 days of the date when I received the HEPZATO KIT. I understand that to receive copay assistance, either I or my healthcare provider must submit an Explanation of Benefits (EOB) or a Remittance Advice (RA) to the Program at 888-845-8593.
- I understand that the EOB or RA must show my out-of-pocket costs. I understand that copay assistance will only be provided for the HEPZATO KIT(S) I received. I understand the Delcath may alter or discontinue HEPZATO KIT ACCESS 360 at any time.
- I declare that I have commercial insurance and that I do not have any insurance coverage for the HEPZATO KIT through a state or federal healthcare program, including but not limited to Medicare, Medicaid, Veterans Affairs (VA), or Department of Defense (DOD), (collectively Government Programs).
- I understand that if my insurance situation changes and I enroll in a Government Healthcare Program, I will no longer be eligible for HEPZATO KIT ACCESS 360. I declare that neither I nor my healthcare provider will seek reimbursement from my health insurers for any part of the benefit received from HEPZATO KIT ACCESS 360.

Patient Signature: _____ Date: _____

Patient Name (print): _____

Please see full Prescribing Information, including Boxed Warning.

Delcath®