



Co-pay Savings Program for Kyleena® Quick Reference Guide

This guide provides easy to follow step by step information on the enrollment process and reimbursement process for the Copay Savings Program for Kyleena.

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(levonorgestrel-releasing
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Enrollment Process:

- HCP/Patients enroll by visiting **CopayforKyleena.com**
- Select the option below if you are:
 - Enrolling as a patient
or
 - Enrolling as a healthcare provider
on behalf of a patient
- Commercially insured patients can be enrolled effective June 16, 2020



STEP 1: Eligibility

- HCP/Patient complete eligibility questions and click submit to continue to the next page.
- If answers to questions determine patient is not eligible for the program, the next page will say:

"We're sorry. Unfortunately you do not meet the program eligibility criteria and are ineligible to receive commercial co-pay assistance for Kyleena. If you have any questions, please contact 1-833-244-2719."

The screenshot shows the 'Eligibility For Patients' form. It includes a progress bar with three steps: ELIGIBILITY (current), PATIENT INFORMATION, and PATIENT INSURANCE. The form contains several questions with checkboxes for 'Yes' and 'No':

- Required Field***
- Are you a United States Resident?***
- Do you currently have commercial health insurance for a portion of your prescription drug cost?***
- Are you enrolled in any federal or state subsidized healthcare program that covers a portion of your prescription drug costs, including Medicare (such as Medicare Part D prescription drug benefit), Medicaid, TRICARE, or any other federal or state healthcare plan, including pharmaceutical assistance programs?***

Below the questions, there is a section for terms and conditions, followed by a 'Submit' button.

STEP 2: Patient Information

- If the HCP/Patient are eligible they will be taken to the next page where the patient's information is entered.
- Patient information includes:
 - Name
 - Phone Number
 - Date of birth
 - Email
 - Address
 - Patient Consent

The screenshot shows the 'Patient Information' step of the enrollment process. It includes a progress bar with three steps: ELIGIBILITY, PATIENT INFORMATION (current), and PATIENT INSURANCE. The form fields are: First Name*, Last Name*, Caregiver, Date of Birth* (MM/DD/YYYY), Gender* (Male/Female), and Address*. A 'Required Field*' label is present. A preview of the Co-pay Savings Program card for Kyleena is shown on the right, listing details like BIN, PCN, GRP, and ID#.

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STEP 3: Patient Insurance Information

- HCP/Patient will need to enter the patient insurance information and click "Enroll".
- Patient insurance information includes:
 - BIN
 - PCN
 - Group
 - Member ID
 - Primary Payer Name

The screenshot shows the 'Patient Insurance' step of the enrollment process. It includes a progress bar with three steps: ELIGIBILITY, PATIENT INFORMATION, and PATIENT INSURANCE (current). The form fields are: Primary Insurance BIN*, Primary Insurance PCN*, Primary Insurance Group*, Primary Insurance Member ID*, and Primary Payer Name*. A 'Required Field*' label is present. A preview of the Co-pay Savings Program card for Kyleena is shown on the right, listing details like BIN, PCN, GRP, and ID#.

Congratulations!

- Once the HCP/Patient has clicked "Enroll" the next page will display a Congratulations message providing the patient's Co-pay Savings Program for Kyleena's information with instructions on how to use it.
- The HCP/Patient can choose to print this page.
- A welcome email will be sent to the patient with the same information.

The screenshot shows the 'Congratulations!' page. It includes a 'Contact us' link at the top. The main text reads: 'Welcome to the Co-pay Savings Program for Kyleena! For your records, please keep this co-pay card information in the image to the right, which includes your: Rx BIN number, PCN number, Group number, Co-pay Program ID. To ensure your savings is applied to your prescription out-of-pocket costs for Kyleena, please provide the information above to your Healthcare Provider. If you have any questions or issues regarding the use of this program, please call us at 1-833-244-2719.' A 'Print' button is located at the bottom. A preview of the Co-pay Savings Program card for Kyleena is shown on the right, listing details like BIN, PCN, GRP, and ID#.

HCP Co-pay Claim Reimbursement Process:

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- Practice submits a claim for reimbursement to patient's insurance company using the CMS 1500 Form.
 - The CMS 1500 Form is commonly used by practices and is available to download on CoplayforKyleena.com under "Forms"
- Practice submits the following documents to ConnectiveRx (CRx) via fax or mail:
 - Completed and signed CMS 1500 form**
 - Patient's explanation of benefits (EOB) or patient's explanation of payment (EOP)
 - Please write the patient's Co-pay Savings Program for Kyleena ID on either the CMS 1500 Form or EOB
- Please note:** The practice has 180 day from the date of EOB to submit to CRx for reimbursement.

EOB example is for demonstration purposes only

- Once CRx receives the paperwork, they will begin to process the claim.
- If claim is approved:**
 - A claim approval fax will be sent to the practice
 - A reimbursement check will be mailed to the practice within 5-7 business days of the claim being approved
- If claim is denied:**
 - A claim pending/rejection fax will be sent to the practice indicating what action is needed to correctly process the claim
 - Practice resubmits claim and review process starts over
- Once the claim is approved, a reimbursement check will be mailed to the practice within 5-7 business days.

Images are for demonstration purposes only

Patient Co-pay Claim Reimbursement Process:

- Patient contacts CRx to obtain a Bayer Co-pay Expenditure Form by calling 1-888-412-2247
- Patient submits the **completed** and **signed** Bayer Co-pay Expenditure Form along with their EOB and/or EOP to CRx via fax or mail
 - Patient will need to write the date of service on the form
- **Please note:** The patient has 180 days from the date of EOB to submit to CRx for reimbursement.
- Once CRx receives the paperwork, they will begin to process the claim.
- **If claim is approved:**
 - A claim approval letter will be sent to the patient
 - A reimbursement check will be mailed to the patient within 5-7 business days of the claim being approved
- **If claim is denied:**
 - A claim pending/rejection letter will be sent to the patient indicating what action is needed to correctly process the claim
 - Patient resubmits claim and review process starts over
- Once the claim is approved, a reimbursement check will be mailed to the patient within 5-7 business days.

Bayer \$0 Co-pay Assistance Programs


Co-pay Expenditure Form Instructions

Please follow the instructions below for completing and submitting a Co-pay Expenditure Form for a Bayer \$0 Co-pay Assistance Program. This form will be required for a patient to be reimbursed for their out-of-pocket expense if co-payment is paid by the patient.

- For each co-pay/coinsurance reimbursement request, please provide the following information:
 - Date of Service
 - Amount of co-pay/coinsurance reimbursement being requested for your Bayer product
 - When the check should be made payable
 - Important Note: The reimbursement check can only be made payable to the patient or person who paid the co-pay amount.
 - Address to which the check should be mailed
 - Proof of payment from pharmacy where co-pay was made
- The Co-pay Expenditure Form MUST be signed and dated. AND all required documentation to:
 - Bayer \$0 Co-pay Assistance Programs
 - C/O ConnectiCare Claims Processing Center
 - P.O. Box 2355
 - Morristown, NJ 07962
- Proof of payment MUST be included with the Co-pay Expenditure Form. Receipts, explanation of benefits and/or claims that include a NDC number, MUST be included in order to be reimbursed. Reimbursement cannot be issued without acceptable proof.
- Payment will be sent within 7 to 14 business days after approval.
- Co-pay expenses incurred prior to your enrollment in the \$0 program eligibility term has ended, may not be eligible.

If you have any questions regarding the Co-pay Expenditure Form or contact Bayer's \$0 Co-pay Assistance Program at 1-888-412-2247 on Friday.

IMPORTANT NOTICE: This program is not valid for prescriptions eligible Medicaid, Medicare (including Medicare Part D), or other federal or state assistance programs. This program cannot be combined with any other. This program is not transferable, is good only in the United States program is subject to certain eligibility requirements. Bayer reserves the right to monitor participation, ensure equitable product availability and modify assistance program at any time. By using this program, you understand and agree to these terms. This program is not insurance.

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Bayer \$0 Co-pay Assistance Programs

Please make additional copies of this form for future use.

Section 1 – Bayer Co-pay Assistance Reimbursement Form

ALL fields are required. Complete this form in its entirety and include supporting documentation to avoid delays in reimbursement.
The following 6 fields can be found on the pharmacy receipt:

Product Name: _____ Received/Date of Service (MM/DD/YYYY): _____
NDC: _____ Rx#: _____
Quantity: _____ Day Supply: _____
Patient First Name: _____ Patient Last Name: _____
Patient Date of Birth: _____ Co-pay Card Member ID: _____
Primary Payer/Insurance Name: _____ Primary Payer ID: _____
Primary Payer Group Number: _____
Amount of Reimbursement Requested (Documentation Required): _____
Make Check Payable to: _____
(Check can only be made payable to the patient or person who paid co-pay amount)
Address: _____
City: _____ State: _____ Zip: _____

Section 2 – Declaration


I verify that the information provided on this form is complete and accurate. I further understand that reported information may be verified by an audit as deemed necessary by the Bayer's \$0 Co-pay Assistance Program. I understand that assistance will terminate if the Program reasonably suspects any fraudulent activity relating to the assistance provided by the Program. I understand that assistance may be limited to the terms and conditions established by the Program and that the Program reserves the right at any time or for any reason, and without notice to (i) modify this form, (ii) modify or discontinue any or all of the programs and the related eligibility criteria, or (iii) terminate assistance.

I authorize Bayer, the \$0 Co-pay Assistance Program, their employees and agents, third party administrators, and other representatives to obtain information from my healthcare providers and insurance coverage information from my employer, insurance company(ies), or specialty pharmacy(ies) as necessary to complete the reimbursement process or to verify the accuracy of any information provided with this form.

Signature (required): _____ Date: _____

Please mail or fax this completed form along with required documentation to:

Bayer \$0 Co-pay Assistance Programs OR FAX: (844) 622-5475
C/O ConnectiCare Claims Processing Center
P.O. Box 2355, Morristown, NJ 07962

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Fax Transmission

To:	From:
<Practice Name> <Practice Billing Fax Number>	Co-pay Savings Program for Kyleena®
Date: <Date>	Pages: 2

Reference Number: <Claim ID>

Dear <Practice Name>:

Thank you for participating in the Co-pay Savings Program for Kyleena®. We have received and reviewed your submission on behalf of <Practice First Name> <Practice Last Name> and unfortunately are unable to approve the claim for the following reason(s):

- ☐ Incomplete documentation. A copy of the Explanation of Benefits (EOB) is required
- ☐ Missing Co-pay Savings Program for Kyleena patient ID number
- ☐ Missing primary insurance plan information or photocopy of front and back of primary insurance card
- ☐ Missing signature
- ☐ Claim outside of program parameters - please do not resubmit
- ☐ Claim not valid (incorrect drug, strength, NDC) - please do not resubmit
- ☐ Duplicate claim - please do not resubmit
- ☐ Patient is covered under a government plan and is not eligible for the program. Please do not resubmit
- ☐ Other: (open text field for miscellaneous procedural issues)

We apologize for any inconvenience. We will be happy to reprocess your request if your claim is valid and all required information and materials are resubmitted. Please resubmit to the following address:

ConnectiCare
Attn: Co-pay Savings Program for Kyleena®
PO Box 2355
Morristown, NJ 07962
Fax: 1-833-244-2720


To expedite processing, please include this letter with any future correspondence.

If you have already been contacted by our office and have sent in additional information as requested, please disregard this letter. Please feel free to contact us at 1-833-244-2719 if you have any questions.

Sincerely,

The Co-pay Savings Program for Kyleena

You may request not to receive future bills from Bayer HealthCare Pharmaceuticals, Inc. (BHC) Business Unit. To stop receiving such bills, please fill out one of the following: call 1-844-644-3644 or send a fax to 1-800-291-0100, or send an e-mail to privacy@bayer.com or any other. Your fax or communication must include the specific location number of the fax machine(s) at which you do not wish to receive bills from us. We will remove your name from our list and will not send you additional bills. Failure to comply with your request within 30 days is unlawful. If you wish to receive bills from us after you have requested to be removed from our list, you must provide express consent to receive such bills at the fax number, telephone number or e-mail address listed above.

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