DUROLANE® Patient Assistance Product Request

bioventus®
Bioventus LLC
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Bioventus LLC is committed to providing access to DUROLANE to patients without the financial resources to pay for the treatment by providing Patient Assistance Product at no cost. To request assistance for treatment of a patient, please complete and return the following information to Bioventus Active Healing Therapies Customer Service via fax (866.832.7284) or email (CustomerServiceUSA@bioventusglobal.com).

PLEASE PRINT Date of Request:_____ Patient Record ID:_____
(DO NOT PROVIDE PHI)

Physician Name:_____

Professional Designation: (e.g., MD, DO, PA):_____ NPI Number:_____

Practice Name:_____

Practice Contact Name:_____ Office Phone:_____

Account Address:_____ Suite:_____

City:_____ State:_____ ZIP:_____

Current Customer: ☐ Yes ☐ No Account No.:_____

Product: DUROLANE [1 unit per knee] Bilateral: Yes ☐ No ☐

Physician Certification

I am requesting DUROLANE Patient Assistance Product from Bioventus for my Patient who cannot afford Bioventus' treatment and verify that the following information is complete and accurate:

1. I have prescribed the Patient Assistance Product for my Patient based on my professional judgment of medical necessity and I will only use the requested Product for the treatment of this Patient;
2. This Patient has an annual household income of less than or equal to 250% of the current Federal Poverty Level, as defined annually by the Department of Human and Health Services, and I have reviewed the current HHS guidelines (to access current Federal Poverty Level details, please visit: https://aspe.hhs.gov);
3. I will not resell, trade, or return for credit any Patient Assistance Product;
4. I will not bill this Patient or any government program or commercial payer for the Patient Assistance Product, injecting the Patient Assistance Product, or other services necessary to the administration of the Patient Assistance Product;

   and
5. I will maintain records sufficient to demonstrate compliance with the statements herein and, if requested, provide such records to Bioventus.

I understand that Bioventus will ship the requested Patient Assistance Product marked "PATIENT ASSISTANCE PRODUCT NOT FOR RESALE" directly to the address provided.

My signature certifies that the Patient Assistance Product I receive from Bioventus for treatment of this Patient will be used according to the terms listed above.

Physician Signature (**no copies or stamps**):_____ Date:_____

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INTERNAL USE ONLY: Acct No.:_____