Fetroja® (cefiderocol) Patient Assistance Program Application

Provides eligible, uninsured patients Fetroja at no cost, through healthcare institutions, clinics, and home infusion sites throughout the country.
To be eligible to receive free medicine from Shionogi, patients must meet all of the following criteria:

- Have no commercial, government, or other insurance coverage
- Have an annual household income at or below 300% of the Federal Poverty Level
- Must reside in the U.S. or applicable U.S. territory
- Have either (1) a valid prescription for an FDA-approved indication for Fetroja from a healthcare provider licensed in the U.S., or (2) a susceptibility test that confirms Fetroja is the only option for treatment

Shionogi Access Support (SAS) offers the following access program: FETROJA PATIENT ASSISTANCE PROGRAM (FPAP). SAS provides medicine at no cost to qualifying patients. Participation in our program is free; we do not collect any fees from people seeking our assistance. Medication assistance is dependent on the patient's ability to meet the eligibility criteria for our program as determined by SAS. Shionogi and SAS do not have any obligation to provide the program services and are not liable in the provision of these services. The FPAP may be changed or discontinued without notice. By applying for the FPAP, each patient and their healthcare provider both agree not to seek reimbursement for any products dispensed under the FPAP. Patients enrolled in the FPAP must notify the FPAP if they obtain insurance or if their financial situation changes. If this application is completed by a patient's personal representative, the personal representative must provide a copy of the completed application to the patient.

Shionogi Access Support
Fetroja Patient Assistance Program
Patient Enrollment Form
TO BE COMPLETED BY PATIENT OR CAREGIVER (Please print clearly)

Please email this completed form to accesssupport@shionogi.com

Patient Information

Last Name_____ First Name_____

Date of Birth_____ Gender_____

Mailing Address_____ City_____ State___ Zip_____

Phone_____ Email Address_____

Insurance & Financial Information

Insurance Type: ❑ No Insurance ❑ Medicare ❑ Medicaid ❑ Private

Employer Name: _____

Annual Household Income: _____

# of Persons residing in household: ___

Patient Consent to Enrollment Terms

By signing below:

• I confirm that I do not have any commercial, government, or other insurance. I understand that this information will be used to determine my eligibility for assistance from the FPAP, to perform an electronic income verification, and I may be required to provide additional financial documentation for consideration.

• If I am enrolled in the FPAP, I agree to immediately notify the FPAP if my health insurance status changes in the future, if I obtain any new health insurance plan, or if I become entitled to, or enroll in a government health insurance program/payer (i.e., Medicare or Medicaid).

• I understand that the FPAP reserves the right to modify, change, or terminate the FPAP program at any time with or without notice.

• I understand that information from FPAP program participants may be summarized for statistical or other purposes, but such summaries will not contain information that identifies me personally.

• I understand that Shionogi, through the FPAP, is collecting patients' relevant financial income and personal health information, including information relating to medical conditions, treatment, care management, prescriptions, and health insurance, for the purpose of determining patients' eligibility for the FPAP and subsequently administering the program benefits or related services.

Patient or Legal Representative/Guardian Signature – **By signing below, I confirm that I have read, understand, and agree to the terms of the above Patient Consent.**

Patient Name: _____

Patient Signature: _____ Date: ____

Legal Representative/Guardian Signature on Behalf of Patient

Name: _____

Signature: _____ Date: ____

Relationship to Patient: _____

Patient Authorization for Use and Disclosure of Health and Other Personal Information

By signing below:

• I authorize my physician(s), pharmacist(s), other healthcare providers, patient advocacy organizations, and insurance companies ("My Providers and Plans") to disclose my health and other personal information relevant to my diagnosis of and treatment for one or more conditions for which I may be or have been prescribed Fetroja® (cefiderocol), including my financial information, insurance status, and any other information relevant to payment for such diagnosis and treatment ("My Health Information") to Shionogi Inc. and its agents and representatives, including any company that assists Shionogi in connection with its FETROJA PATIENT ASSISTANCE PROGRAM (collectively, "Shionogi") in order that I may participate in the FETROJA PATIENT ASSISTANCE PROGRAM ("FPAP").

• Shionogi may use My Health Information obtained pursuant to this Authorization in order to: (1) contact me by mail, email, and/or telephone to enroll me in Shionogi's FPAP; (2) provide me with materials relating to the FPAP; (3) verify the accuracy of the information I provide and in my application for the FPAP; (4) provide me with FPAP support services; and (5) conduct quality assurance, surveys, and other internal business activities in connection with the FPAP. Shionogi also may exchange My Health Information with My Providers and Plans to assist me in connection with my treatment with Fetroja®.

• I understand that this Authorization will remain in effect for ten (10) years from the date of my signature below, or such shorter period as may be required by state law, unless I revoke the Authorization earlier.

• I understand that I may cancel this Authorization at any time by sending a request in writing to Shionogi at accesssupport@shionogi.com. I understand that if I do cancel this Authorization, it will end my enrollment in the FPAP. I also understand that cancelling this Authorization will invalidate any use or disclosure of My Health Information made in reliance on this Authorization prior to Shionogi's receipt of my notice of cancellation.

• I understand that my refusal to sign this Authorization will not affect my ability to receive Fetroja, other health care treatment, payment for treatment, or eligibility for or enrollment in health benefits; however, such refusal will make me ineligible to receive support services for Fetroja through the FPAP.

• I understand that once My Health Information is disclosed pursuant to this Authorization, it may no longer be protected by certain federal privacy regulations and could be re-disclosed to others.

• I understand that I have the right to receive a copy of this Authorization.

By signing below, I confirm that I have read, understand, and am signing the above Authorization for Use and Disclosure of Health and Other Personal Information.

Patient Name: _____

Patient Signature: _____ Date: ____

Legal Representative/Guardian Signature on behalf of Patient

Name: _____

Signature: _____ Date: ____

Relationship to Patient: _____

FOR HEALTHCARE PROVIDER USE ONLY

Physician Information

Prescriber's Name: _____

NPI#: _____ SLN: _____ SLN Expiration Date: _____

Office Phone: _____ Mobile Phone: _____

Email Address: _____ Fax: _____

Address: _____ City:_____ State: ___ Zip:_____

Prescription Information

Medication	Dose	# of Vials	Purpose	Start Date	End Date
Fetroja (cefiderocol) 1 gram/vial, 10 vials per carton			__Complicated Urinary Tract Infection __Hospital-acquired Bacterial Pneumonia or Ventilator-associated Bacterial Pneumonia __Other (Please specify and provide a copy of susceptibility test confirming Fetroja is the only option for treatment)		

Site of Infusion Information

Facility or Home Infusion: _____

Address: _____ City:_____ State:___ Zip:_____

Contact Person Name:_____ Phone:_____ Email:_____

Shipping Address Information

Address: _____ City:_____ State:___ Zip:_____

Please indicate the preferred times and days of the week for delivery of the shipment of Fetroja to your facility:

Monday, Tues, Wed, Thurs, Fri, Sat, Sun – AM/PM

Please provide a shipping contact name (other than prescribing physician)

Name: _____

Phone: _____

Email: _____

Fetroja is required to be stored refrigerated at 2°C to 8°C (36°F to 46°F). Protect the carton from light. Store in the carton until time of use. Please ensure someone will be available to receive shipment at the specified time and date.

To request medical information, report an adverse event (medication side effect), or report a product complaint, call (800) 849-9707 or email medinfo@shionogi.com.

Treating Physician Certification for the Shionogi FPAP

I agree to and certify:

• Fetroja is medically appropriate for the patient identified above and that I, or a physician in my practice, will be supervising the patient's treatment.

• The FPAP is a patient assistance program available to assist patients, and that program participation is voluntary, and that patient eligibility for services is not connected to or contingent on any past or future purchase or prescribing of Fetroja.

• If the patient applies for and is eligible for free product through the FPAP, I will not seek reimbursement for the provided product from any insurance company or program, including federal healthcare programs such as Medicare or Medicaid. Additionally, I agree to notify the FPAP immediately if the patient is no longer receiving Fetroja through the FPAP and agree to return unused free product to the FPAP.

• I understand that information concerning program participants may be summarized for statistical or other purposes and provided to Shionogi.

• The information provided on the enrollment form is complete and accurate to the best of my knowledge.

• The FPAP reserves the right to modify, change, or terminate the FPAP program at any time with or without notice.

• I understand that Shionogi is collecting physicians' relevant personal information to document that it has obtained the required certifications and authorizations to administer the FPAP.

Coverage and reimbursement decisions are made by insurance companies following the receipt of claims.

Shionogi's Privacy Policy can be found here: https://www.shionogi.com/us/en/privacy-policy.html#Collection

Physician Prescription Signature – **I certify that the information I have provided above is accurate to the best of my knowledge.**

Prescriber Name: _____ Prescriber Signature: _____ Date: ____

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