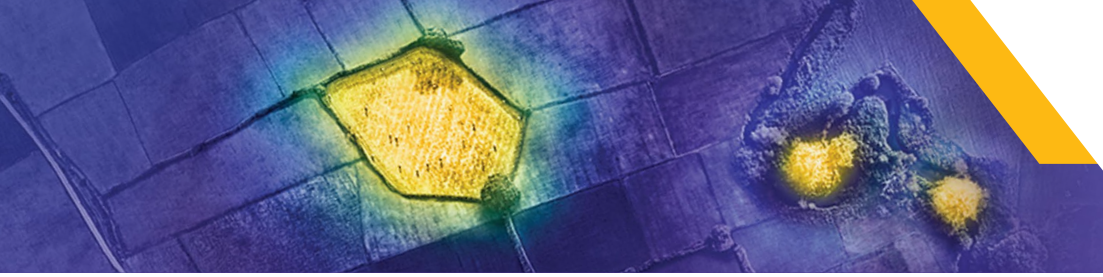

AXUMIN®
Fluciclovine F 18 Injection

Patient Benefit Investigation Form

Phone: 1-855-495-9200 | Fax: 1-877-309-7514 | Email: reimbursement@blueearthdx.com

REQUESTED SERVICE

☐ Benefit investigation only ☐ Prior authorization assistance
☐ Appeal/denial assistance

PATIENT AUTHORIZATION TO SHARE HEALTH AND USE INFORMATION

Printed name

_____

The following information should be filled out by your healthcare provider

HCPCS: ☐ A9588 ☐ Other: _____

CPT® codes: ☐ 78812 ☐ 78813 ☐ 78815 ☐ 78816
☐ Other: _____

Diagnosis code C61 ☐ Yes ☐ No
Diagnosis code Z85.46 ☐ Yes ☐ No
Diagnosis code R97.21 ☐ Yes ☐ No

Other diagnosis codes:

Suspicion of recurrent disease after previously treated prostate cancer: ☐ Yes ☐ No

Suspected recurrence based on:

Elevated PSA levels: _____

Prior studies/treatment: _____

Radical prostatectomy ☐ Yes ☐ No Date: _____

Radiation therapy to prostate ☐ Yes ☐ No Date: _____

Other treatments: _____ Date: _____

Previous imaging studies: ☐ CT ☐ MRI ☐ Bone scan
☐ Other: _____

I verify that the patient and physician information contained in this enrollment form is complete and accurate to the best of my knowledge and that I have prescribed Axumin based on my professional, independent judgment of medical necessity and it will be used as directed. I certify that I have received the appropriate permission from the patient and met any other applicable requirements imposed under the Health Insurance Portability and Accountability Act of 1996 and/or state law needed to release the above information to Blue Earth Diagnostics and its agents for the purposes of verifying the patient's insurance coverage, on my patient's behalf, and providing information on prior authorization and/or appeals for denials of claims. I authorize the Axumin Reimbursement Support Helpline Program to perform a preliminary assessment of insurance and benefit investigation for the above-named patient, and I further authorize and request that the Program provide to me information regarding Axumin for my reference in completing documentation as may be required by the patient's health plan. I further authorize Axumin Reimbursement Support to submit, at my request, information provided by me on this form and documentation completed by me to applicable health plans.

_____ _____

Prescriber signature required (no stamps) Date

PATIENT DEMOGRAPHIC INFORMATION

First name _____ MI _____
Last name _____
Address _____
City _____ State _____ ZIP _____
Mobile phone # _____ Last 4 of SSN _____
Email _____ DOB _____
Primary insurance _____
Policy holder _____ Group # _____
Policy # _____ Phone # _____
Secondary insurance _____
Policy holder _____ Group # _____
Policy # _____ Phone # _____

NOTE: Copy of insurance card(s) acceptable in lieu of completing insurance information above. Please include both sides of card.

REFERRING PHYSICIAN INFORMATION

Physician name _____
Physician specialty _____
Practice name _____
Practice address _____
City _____ State _____ ZIP _____
TIN # _____ Medicare PTAN _____
NPI # _____
Contact person _____
Contact phone # _____ Fax # _____
Contact email _____

SITE OF AXUMIN PET/CT SCAN

☐ Hospital outpatient ☐ Physician practice
☐ Independent diagnostic testing facility
☐ Other: _____
Name of facility _____
TIN # _____ Medicare PTAN _____
NPI # _____
Facility contact name _____
Facility contact phone # _____
Facility contact email _____

Please see Axumin Important Safety Information on back.

Patient Benefit Investigation Form

AXUMIN®
Fluciclovine F 18 Injection

PATIENT AUTHORIZATION TO SHARE HEALTH INFORMATION

I understand that I must authorize the use and disclosure of certain personal health information ("PHI") before I can receive assistance through the Axumin Reimbursement Support Helpline Program (the "Program"). I hereby authorize my healthcare providers, pharmacies, and health plan(s) to disclose my PHI related to my medical condition and treatment, and all information provided on this patient enrollment form, to Blue Earth Diagnostics, the manufacturer of Axumin, and to its agents and the administrator of the Program (collectively, the "Recipients"). I further authorize the Recipients to use and disclose my PHI for the purposes of establishing my eligibility for benefits from my health plan or other programs, providing educational and reimbursement support, communicating with my healthcare providers and health plan(s), and for Blue Earth Diagnostics' internal business purposes, including quality control and compliance. I understand that signing this authorization is voluntary and that if I were to refuse to sign, that would not affect my eligibility for health plan benefits or ability to obtain treatment by my healthcare providers. I also understand, however, that if I refuse to sign, I will not have access to the services offered by the Program. I also understand that if I sign this authorization, I can cancel it at any time by notifying Blue Earth Diagnostics in writing at reimbursement@blueearthdx.com. Upon receiving my notice of cancellation, Blue Earth Diagnostics would stop using this authorization to access, use, or disclose my PHI, and would notify my healthcare providers and health plan(s) of the cancellation, but the cancellation would not invalidate reliance on the authorization prior to its cancellation. I understand that once disclosures of my PHI pursuant to this authorization have occurred, that PHI may no longer be protected by certain federal or state privacy laws and therefore could potentially be re-disclosed to others.

This authorization will expire 5 years after the date it is signed below or at such earlier time as may be required by applicable state law. I have read this authorization or have had it explained to me. I understand that I will receive a copy of this authorization after I sign it.

Patient signature	Date

Abbreviations: CPT, current procedural terminology; HCPCS, Healthcare Common Procedure Coding System.

INDICATION

Axumin® (fluciclovine F 18) injection is indicated for positron emission tomography (PET) imaging in men with suspected prostate cancer recurrence based on elevated blood prostate specific antigen (PSA) levels following prior treatment.

IMPORTANT SAFETY INFORMATION

- Image interpretation errors can occur with Axumin PET imaging. A negative image does not rule out recurrent prostate cancer and a positive image does not confirm its presence. The performance of Axumin seems to be affected by PSA levels. Axumin uptake may occur with other cancers and benign prostatic hypertrophy in primary prostate cancer. Clinical correlation, which may include histopathological evaluation, is recommended.
- Hypersensitivity reactions, including anaphylaxis, may occur in patients who receive Axumin. Emergency resuscitation equipment and personnel should be immediately available.
- Axumin use contributes to a patient's overall long-term cumulative radiation exposure, which is associated with an increased risk of cancer. Safe handling practices should be used to minimize radiation exposure to the patient and health care providers.
- Adverse reactions were reported in ≤1% of subjects during clinical studies with Axumin. The most common adverse reactions were injection site pain, injection site erythema and dysgeusia.

To report suspected adverse reactions to Axumin, call 1-855-AXUMIN1 (1-855-298-6461) or contact FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

Please see accompanying full Axumin Prescribing Information, also available at www.axumin.com.

BLUE EARTH DIAGNOSTICS
A Bracco Company

BEDPRC21-0074 9/21