MERZ CONNECT™

Contact the MERZ CONNECT™ Support Line
1-844-4MYMERZ (1-844-469-6379), option 4
Monday – Friday 8am – 7pm ET
Fax 1-855-825-0488
Email MERZCONNECT@lashgroup.com

XEOMIN® incobotulinumtoxinA

BENEFIT VERIFICATION FORM

PATIENT INFORMATION

Patient First Name _____ Patient Last Name _____ MI ____
Date of Birth (MM/DD/YYYY) _____ Gender ☐ M ☐ F
Street Address _____ City _____ State _____ Zip _____
Preferred phone # _____
Legal Guardian Name _____ Relationship to Patient _____
Legal Guardian Phone _____ Patient/Legal Guardian Email *(Required)* _____

INSURANCE INFORMATION *(Please attach a copy of the front and back of the patient's insurance card)*

PRIMARY Insurance Name _____ Phone Number _____
Policy holder _____ Policy holder ID # _____ Group ID # _____
Policy holder Date of Birth (MM/DD/YYYY) _____ Policy holder's Relationship to Patient _____

SECONDARY Insurance Name _____ Phone Number _____
Policy holder _____ Policy holder ID# _____ Group ID# _____
Policy holder Date of Birth (MM/DD/YYYY) _____ Policy holder's Relationship to Patient _____

HEALTHCARE PROVIDER INFORMATION

Healthcare Provider Name _____ Email _____
Facility Name _____
Street Address _____ City _____ State _____ Zip _____
Phone # _____ Ext # _____ Secure Fax # _____
Office Contact Name _____ Office Contact Phone # _____
National Provider Identification (NPI) # _____ State License # _____ Medicare Provider # _____
Blue Cross Provider # _____ Group Tax ID # _____
May we contact your patient? ☐ Yes ☐ No
Place of Service *(check all to be verified)*

☐ Physician Office (11) ☐ Hospital Inpatient (21) ☐ Ambulatory Surgical Center (21)
☐ Hospital Outpatient (22) ☐ Skilled Nursing (31) ☐ Other *(Please Specify)* _____

How will you supply the medication? ☐ Buy and Bill ☐ Specialty Pharmacy *(Name)* _____
Place of Service Name *(if different from above)* _____ Address _____
If the patient's insurer requires prior authorization, would you like assistance pursuing it? ☐ Yes ☐ No

Please scan the QR code on page 2 to see Important Safety Information, including BOXED WARNING, or visit XEOMIN.com for Full Prescribing Information.

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TREATMENT INFORMATION

Diagnosis Code 1 (ICD-10) _____ CPT Code 1 _____

Diagnosis Code 2 (ICD-10) _____ CPT Code 2 _____

☐ **95873** Electrical stimulation for guidance in conjunction with chemodenervation code

☐ **95874** Needle electromyographic guidance (EMG) in conjunction with chemodenervation code

☐ **76942** Ultrasound guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision, and interpretation

Injection Sites _____ # of Units Anticipated _____ Treatment Date (MM/DD/YYYY) _____

HEALTHCARE PROVIDER CERTIFICATION

The MERZ CONNECT Support Line has been developed by Merz. The program is operated by Merz Pharmaceutials, LLC (Merz), including by way of third party administrators, to help patients needing XEOMIN. A representative of the MERZ CONNECT Support Line may contact you for additional information.

By checking Yes below, you are certifying that the described therapy is medically necessary for the patient for which you are seeking access support and that you have received the necessary authorization from the patient/patient's guardian to release the below referenced medical and/or other patient information relating to XEOMIN therapy to Merz and its third party administrators for the following purposes:

- To provide education al support in verifying patient/patient's minor child's insurance eligibility and coverage for XEOMIN (including medical and/or pharmacy benefit and specialty pharmacy options) and in seeking reimbursement for XEOMIN therapy;
- To assist in initiating and/or continuing XEOMIN therapy;
- To assess potential eligibility for patient/patient's minor child's participation in the XEOMIN Patient Savings Program and/or the XEOMIN Patient Assistance Program;
- To contact patient/patient's minor child's doctor and the rest of patient/patient's minor child's healthcare team and share with them pertinent health information that may be useful for care; and
- To improve, develop, and evaluate products, services, materials and programs related to patient/patient's minor child's condition or treatment.

By submitting this information, you certify that your patient has consented to your disclosure of the patient's personal health information to Merz and its third party administrator for insurance verification an prior authorization support.

Healthcare Provider Certification ☐ Yes ☐ No

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MERZ THERAPEUTICS