PRIALT® Assurance

TerSera® therapeutics | PRIALT® (ZICONOTIDE) INTRATHECAL INFUSION

Practice Enrollment Form

Please complete and submit by emailing to PRIALTassurance@tersera.com.
UNREDACTED PATIENT INFORMATION WILL NOT BE ACCEPTED.

1 PRACTICE INFORMATION

Practice Name: _____
Site Name (if applicable): _____
Site Address: _____
City: _____ State: _____ ZIP: _____
Check Remittance Address (if different from above): _____
City: _____ State: _____ ZIP: _____
Telephone: ( ) _____
Fax: ( ) _____
Office Contact: _____ Office Email: _____ Best Time to Call: _____

2 PROGRAM GUIDELINES

This agreement confirms that the purchasing physician and provider site understands and agrees to the following terms of the TerSera PRIALT Assurance program:

1. The practice is only required to submit this enrollment form once to enroll in the TerSera PRIALT Assurance program. This can be completed after the patient receives treatment.
2. The TerSera PRIALT Assurance program is for patients who have insurance with confirmed coverage for PRIALT.
3. TerSera SupportSource must conduct and document a benefit verification for PRIALT before a patient receives treatment.
4. If TerSera SupportSource confirmed that the patient has coverage for PRIALT, that is prescribed by the patient's physician, the claim may be eligible for replacement product under the program. The provider must then follow all payer guidelines (prior authorizations, pre-determinations, etc) and timely file all claims and appeals in accordance with payer policy.
5. If the appropriately billed claim(s) is (are) denied, the provider will send a redacted copy of the claim(s) submitted, all explanation of benefits (EOB) to the program, and documents related to the benefit verification by TerSera SupportSource. Partial payment is not considered a denial.
6. The provider must submit at least one level of appeal following all payer guidelines. If the claim is denied again (not partially paid), the provider will be eligible to receive replacement product upon receipt of all required documentation. Requested documentation includes redacted claim submission, patient EOB, and first-level appeal denial by the patient's insurance provider (only required for initial denied date of service).
7. To be eligible for a replacement, PRIALT must be purchased through McKesson Specialty and used as monotherapy.
8. The TerSera PRIALT Assurance program is not payer specific. Both physician offices and hospitals are eligible if PRIALT is given to an insured patient on an outpatient basis.
9. Request for replacement product must occur within six months of the patient's treatment date.
10. The TerSera PRIALT Assurance program is limited to two replacement products per calendar year, per physician, so long as the payers are different for each claim.
11. If the claim does not meet the above guidelines, then PRIALT is not eligible for replacement product by the TerSera PRIALT Assurance program and will not be subject to the benefits of the program.
12. The TerSera PRIALT Assurance program reserves the right to make eligibility guidelines, terminate, or modify this program at any time for any reason.
13. Agree to return any copayment, co-insurance, or any other payments made by patient or the payer, or any other party specific to the TerSera PRIALT Assurance program and the replacement product being issued.
14. Understand that the TerSera PRIALT Assurance program and the other product support programs offered by TerSera Therapeutics do not impose any purchase obligation at any time or in any manner. Use of PRIALT may be discontinued at any time, without penalty.
15. **IF UNREDACTED PATIENT INFORMATION IS SUBMITTED, IT WILL BE DELETED AND YOUR CLAIM WILL NOT BE PROCESSED.**

The individual signing below represents that he or she has the appropriate authority on behalf of the purchaser to enter into this agreement and the authority to enter into this agreement on behalf of the practice listed on this form.

Physician or Provider Contact Signature: _____ Date: _____
Name (printed): _____ Title: _____

I attest that the information supplied is complete and accurate. I understand this information is for the sole use of the program, its representatives, and/or agents selected in order to assess eligibility for participation in the PRIALT Assurance program. I understand eligibility under the program is subject to approval under the guidelines, and that the manufacturer reserves the right to change or terminate the program without prior notice. I agree to abide by this certification throughout the practice's participation in the program and to notify the program if aspects of this certification are no longer applicable.

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PRI-P-1145 (01/2023)