Dear Healthcare Professional:

EMD Serono, Inc. is committed to increasing access to fertility treatment. As part of this commitment, we have developed several programs specifically designed to make infertility treatment more affordable.

Compassionate Care is available to eligible patients who may not otherwise be able to afford fertility treatment. The program offers certain EMD Serono fertility medications free of charge including Gonal-f® RFF Pen (follitropin alfa injection) to patients who meet the following eligibility criteria:

- No insurance coverage for fertility medication;
- Currently undergoing fertility treatment with a physician thoroughly familiar with infertility problems and their management;
- US citizen or permanent resident;
- Qualifying annual household gross income based on a standard set of parameters;
- Have not received fertility medications through EMD Serono's Compassionate Care program in the past.

Qualifying income is assessed according to a standard set of parameters including the Federal poverty guidelines, which take into account number of persons in household and state of residence.

Please have your patient complete the attached application and fax or mail it to:

Fertility LifeLines™
12 Kent Way
Byfield, MA 01922
Attn: Compassionate Care Program
Fax: 1-866-882-2900

The patient application will be confidentially evaluated on an individual basis and will not be reviewed until we receive all of their supporting income information, including their most recent 1040 tax return and last two pay stubs and a copy of the front and back of their insurance card. If they meet the eligibility criteria, we will send a product request form to your office as listed on the enclosed patient application. Once your office returns this form we will process the request and ship the product to your office.

We wish your patient the best on their journey to conceive. If you or your patient has any questions about this application or about our Compassionate Care program, please call Fertility LifeLines toll free at 1-866-LETS-TRY (1-866-538-7879).

Sincerely,

David L. Stern
Executive Vice President
Endocrinology

As with all prescription medications, side effects may occur with the use of fertility drugs including Gonal-f RFF Pen (follitropin alfa injection). These products should only be prescribed by doctors specializing in infertility or reproductive health. Fertility drugs can cause serious side effects including, ovarian hyperstimulation syndrome (OHSS), with or without blood vessel and lung problems, and multiple births. For complete product details about a specific fertility drug, please refer to the full prescribing information. Complete product details including instructions for use and safety information for EMD Serono fertility medications are available at www.fertilitylifelines.com or by calling 1-866-LETS-TRY.

RFF: Revised Formulation Female

COMPASSIONATE CARE PATIENT APPLICATION

Send application to:

1-866-882-2900 (FAX)

Patient Information

Patient Name: _____ Social Security # (last 4 digits) _____

Address: _____ City: _____

State: _____ Zip: _____ Phone #: (_____)_____

Date of Birth: _____/_____/_____	US Citizen or Permanent resident: ☐ Yes ☐ No

Number of persons (including self) in household: _____

Total Annual Household Income: Proof of all sources must be attached including 1040 & 2 current pay stubs

Salary/Wages	$	Pension	$
Social Security	$	Investment Income	$
Social Security Supplement	$	Other:	$
Disability	$		$
Unemployment Compensation	$	**TOTAL**	**$**

Insurance

Insurance Company:_____ Cardholder Name:_____

ID#:_____ Group #:_____

Important: Please attach a copy, front and back, of your insurance card

Treatment

Are you currently undergoing fertility treatment with a fertility specialist? ☐ Yes ☐ No

Physician's Name: _____

Center Name: _____ **Fax #:** _____

Address: _____ City: _____

State: _____ Zip: _____ Phone #: (_____)_____

Have you ever received products through the EMD Serono Compassionate Care in the past? ☐ Yes ☐ No

Please include the physician's fax number.

I certify that all of the information in this application is complete and accurate. In order to participate in EMD Serono's Compassionate Care patient assistance program for fertility medications at no cost, I hereby: (1) authorize EMD Serono, Inc., and any third parties working with EMD Serono (collectively, "EMD Serono") to contact my healthcare provider, pharmacy, insurance company or other third-party payers about my medical, financial, insurance or third party payer information (my "Information") and to use and disclose that Information, and (2) authorize those parties to disclose (i.e., release) all such Information to Serono. This authorization is permanent unless I notify Serono in writing that I withdraw it. I understand that in order to participate in EMD Serono's program, I also need to sign a separate "Patient Authorization" form concerning the use and disclosure of my Information and I agree to sign that form. I understand that my prescribing physician is responsible for choosing which prescription products are right for me based on my diagnosis of infertility.

Patient's Signature: _____ *Date:* _____

Application will not be reviewed unless it is 100% complete.

Compassionate Care Patient Authorization Form

Patient's Name: _____
Address: _____
SS # (last 4 digits) _____ DOB: ___/___/___

Authorization to use and disclose medical, financial and insurance information

I confirm that I want to participate in EMD Serono's Compassionate Care patient assistance program ("Program") for fertility medications at no cost. By signing below, I hereby:

(1) authorize EMD Serono, Inc., and any third parties working with EMD Serono Inc., including but not limited to the call center which helps administer the Program (collectively, "EMD Serono") to contact my healthcare provider, pharmacy, insurance company or other third-party payers (collectively, "Third Parties") about my medical, financial, insurance or third party payer information and information to verify the accuracy of the information I provide in my Compassionate Care Patient Application or related to my enrolment or participation in the Program (my "Information") for the purposes described below, and

(2) authorize the Third Parties to disclose (i.e., to release) all such Information to EMD Serono for the purposes described below, and

(3) authorize EMD Serono to use and disclose my Information for those same purposes; and

(4) authorize EMD Serono to disclose Information back to the Third Parties for those same purposes; and

(5) authorize EMD Serono and Third Parties to release Information about me between and among each other for those same purposes.

Purposes for which your Information may be used and disclosed

By signing below, I authorize the use and disclosure of my Information for the following purposes:

- to enroll me in the Program;
- to facilitate dispensing of my prescription to my healthcare provider at no cost;
- to provide me with free medical and clinical information and patient educational materials about my condition, treatment options, products and program offerings;
- to provide me with information about compliance with the treatments my healthcare provider has prescribed;
- to monitor the status of my prescription dispensing and treatment compliance and advise my healthcare provider of such status;
- to conduct surveys to measure my patient satisfaction with the Program and dispensing and delivery of my prescription; and
- for such other purposes as may be required or permitted by applicable law.

Terms of this Authorization

This authorization has no expiration date. It is a permanent authorization (unless and until it is revoked). I understand that: (1) I can revoke this authorization in writing by notifying EMD Serono and the revocation is not effective as to actions any party took in reliance on the authorization, (2) once my Information is disclosed to third parties under this authorization some of it may not be protected, (3) I can refuse to sign this form (but then I can't participate in the Program), (4) EMD Serono reserves the right to, at any time and without notice: (a) modify the application form and the eligibility criteria, (b) modify or discontinue any or all aspects of the program, and (c) terminate any assistance provided by the Program, (5) I have the right to receive a copy of this form and (6) my prescribing physician is responsible for choosing which prescription products are right for me based upon my diagnosis of infertility.

Check this box for more information

❑ I authorize EMD Serono and the Third Parties to send me up-to-date medical and promotional information on my prescription drug and additional Serono programs, services and products which may be of interest to me.

Signature of patient: _____

Date: _____