Welcome to...

access SIVEXTRO™

Single-source support for coordinating care

When you prescribe SIVEXTRO® (tedizolid phosphate) to your patients, our goal is to ensure they have access. That is why AccessSIVEXTRO is committed to helping eligible patients—so they can receive treatment without disruption.



Commercial Copay Program



Medicare/Medicaid Support



Patient Assistance Program



Commercial Bridge Program

Prompt Fulfillment and Delivery

- Same-day pharmacy pick up
- Overnight home delivery

AccessSIVEXTRO
is brought to you by

CUBIST CARES™
Comprehensive Assistance, Resources, Education, and Support

1-844-CUBIST-CARES (1-844-282-4782)
Alt Phone: 1-407-888-5304, Fax: 1-407-888-5305
Monday–Friday, 8:00 AM–8:00 PM ET
Saturday, 9:00 AM–1:00 PM ET

access SIVEXTRO™

Single-source support for coordinating care

Cubist Pharmaceuticals, through AccessSIVEXTRO, is committed to giving eligible patients access to SIVEXTRO (tedizolid phosphate) as quickly as possible. From the moment you submit the enrollment form, your customer service representative will work with you and your patient to determine coverage and eligibility. Our goal is to begin prescription fulfillment within 5 hours so eligible patients can receive therapy without disruption.

Enrollment Confirmation *within 1 hour*

- Fill out the enclosed enrollment form
- Fax the form to **1-844-282-4783** or call **1-844-CUBIST-CARES (1-844-282-4782)**
- A customer service representative will send notification of approval or denial
  - If you have not heard from AccessSIVEXTRO within 1 hour, please call to confirm the fax was received, or phone in the referral directly

Benefit Investigation Assistance *within 1 hour**

If prior authorization is required, your assigned customer service representative will obtain and fill out any required forms and fax them to the prescriber to sign and submit

Financial Assistance Options *within 4 hours*

Your customer service representative can assist with coverage determinations, out-of-pocket cost information, and financial support options

Prescription Fulfillment *within 5 hours*

Once eligibility is determined, your customer service representative will forward the prescription to be filled to a local pharmacy or coordinate the overnight shipment of SIVEXTRO to your patient's home or requested address

*Subject to receipt of a completed and accurate enrollment form.

The AccessSIVEXTRO Program offers:



Commercial Copay Program

Eligible patients will pay no more than $15 out of pocket



Medicare/Medicaid Support

Helps patients identify alternative funding options



Patient Assistance Program

Provides eligible patients with their SIVEXTRO prescription free of charge



Commercial Bridge Program

Ensures eligible patients have access to prescribed therapy by dispensing a supply of SIVEXTRO when prior authorization is delayed

To determine eligibility, call your AccessSIVEXTRO customer service representative.

For more information or for answers to specific questions, call AccessSIVEXTRO at

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AccessSIVEXTRO, a part of Cubist CARES, is committed to helping eligible patients gain access to therapy they need. Because we understand the importance of starting treatment and continuation of care, our customer service representatives will work to forward the prescription for fulfillment **within 5 hours after the enrollment form is submitted.**



Commercial Copay Program

Eligible patients will pay no more than $15 out-of-pocket costs



Medicare/Medicaid Support

Helps patients identify alternative funding options



Patient Assistance Program

Provides eligible patients with their SIVEXTRO (tedizolid phosphate) prescription free of charge



Commercial Bridge Program

For eligible patients when prior authorizations are delayed

Prompt Fulfillment and Delivery

- Same-day pharmacy pick up
- Overnight home delivery

For more information or for answers to specific questions, call AccessSIVEXTRO at

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AccessSIVEXTRO assists healthcare professionals in the determination of whether treatment could be covered by the applicable third-party payer based on coverage guidelines provided by the payer, and patient information provided by the healthcare provider under appropriate authorization following the provider's exclusive determination of medical necessity. Many factors affect third-party reimbursement. Cubist and AccessSIVEXTRO make no representations or guarantees that insurance reimbursement or any other payment will be available. This service is for informational purposes only. Cubist and AccessSIVEXTRO make no representations or warranties, expressed or implied, as to the accuracy of the information. Responsibility for the use of this service is agreed upon and accepted by all providers and other users of this information. Cubist does not guarantee, and assumes no responsibility for the quality, scope, or availability of the AccessSIVEXTRO support services including but not limited to reimbursement support services, patient education, and other support services. AccessSIVEXTRO support services are included within the cost of the product, and have no independent value to providers apart from the product. Cubist reserves the right to rescind, revoke, or amend this offer at any time without notice. Void where prohibited by law.

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AccessSIVEXTRO
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access SIVEXTRO™

Single-source support for coordinating care

AccessSIVEXTRO Enrollment Form

PHONE: 1-844-CUBIST-CARES (1-844-282-4782) **FAX:** 1-844-282-4783 *Please print clearly*
ALT PHONE: 1-407-888-5304 **FAX:** 1-407-888-5305

1. PATIENT INFORMATION

Name _____ DOB _____ Gender _____

Address _____ City _____ State _____ ZIP _____

Email _____ Home phone _____ Cell phone _____

Work phone _____ Best time to contact _____ Patient representative _____ Phone _____

2. INSURANCE INFORMATION

☐ Patient does not have insurance ☐ Insurance information provided below ☐ Copy of both sides of the patient's insurance card attached

Primary insurance _____ Insurance phone _____ Policy ID # _____

Group # _____ Policyholder name _____ Relationship to patient _____

Pharmacy plan _____ Preferred specialty pharmacy _____ Policy ID # _____

Group # _____ RX BIN # _____ RX PCN # _____

3. MEDICAL INFORMATION NEEDED FOR PRIOR AUTHORIZATION SUPPORT

Drug allergies _____ Previous tried and failed therapies _____

Medication needed by date _____ Expected date of discharge ____ / ____ / ____

Culture results _____ Height/weight _____ Other concurrent medications _____

4. PRESCRIPTION INFORMATION

☐ Rx for SIVEXTRO® (tedizolid phosphate): 200 mg PO once daily

Quantity _____

☐ **Bridge Rx: SIVEXTRO (tedizolid phosphate) 200 mg PO once daily (please check for authorization; no cost to patient)**

Quantity _____

In the event there is a delay in securing prescription coverage, I authorize Cubist Pharmaceuticals and their service provider to dispense SIVEXTRO directly to the patient as part of the Commercial Bridge Program.

5. PATIENT CASE MANAGER CONTACT INFORMATION

Contact name _____

Preferred method of contact (please check at least ONE method)

☐ Phone _____ ☐ Fax _____ ☐ Email _____

6. PRESCRIBER INFORMATION

Prescriber name _____ Specialty _____

Hospital name _____ Collaborating physician _____

Address _____ City _____ State _____ ZIP _____

State license # _____ NPI # _____

7. PRESCRIBER SIGNATURE

By signing this form, I certify that therapy with SIVEXTRO is medically necessary for this patient. I will be supervising the patient's treatment accordingly and I have reviewed the current SIVEXTRO prescribing information. I have received the necessary authorization to release medical and/or other patient information relating to SIVEXTRO therapy to Cubist and its affiliates, service providers, and agents to use and disclose my patient's health information as necessary to participate in the AccessSIVEXTRO program, to verify the accuracy of the information provided, to provide reimbursement services, to forward the prescription below to a pharmacy for fulfillment, and (as applicable) to assess my patient's eligibility for patient assistance. In addition, I certify that I shall not seek inappropriate reimbursement for any medication dispensed through the AccessSIVEXTRO program.

I further certify: AccessSIVEXTRO assists healthcare professionals in the determination of whether treatment could be covered by the applicable third-party payer based on coverage guidelines provided by the payer, and patient information provided by the healthcare provider under appropriate authorization following the provider's exclusive determination of medical necessity. Many factors affect third-party reimbursement. Cubist and AccessSIVEXTRO make no representations or guarantees that insurance reimbursement or any other payment will be available. This service is for informational purposes only. Cubist and AccessSIVEXTRO make no representations or warranties, expressed or implied, as to the accuracy of the information. Responsibility for the use of this service is agreed upon and accepted by all providers and other users of this information. Cubist does not guarantee, and assumes no responsibility for the quality, scope, or availability of the AccessSIVEXTRO support services including but not limited to reimbursement support services, patient education, and other support services. AccessSIVEXTRO support services are included within the cost of the product, and have no independent value to providers apart from the product. Cubist reserves the right to rescind, revoke, or amend this offer at any time without notice. Void where prohibited by law.

Doctor/prescriber signature _____ Date _____

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