GRAFAPEX™ PATIENT ENROLLMENT FORM

CORE CONNECTIONS
Coverage, Resources and Education

Phone: 1-84-GRAFAPEX (844-723-2739)
Fax: (800) 481-3325
Email: coreconnectionscare@pharmacord.com
Monday – Friday, 9am – 6pm ET

REQUESTED SERVICES

☐ Benefit & Coverage Investigation ☐ Insurance Appeal Support ☐ Precertification Support
☐ Financial Support (Copay, PAP, Foundation) ☐ Other:

PATIENT INFORMATION

First Name:	**Last Name:**	
Date of Birth:	**Last 4 of SSN:**	**Sex:** ◯ Male ◯ Female
Address:		
City:	**State:**	**Zip:**
Phone Number:	**Email:**	
Preferred Language: ☐ English ☐ Spanish ☐ Other:		
Allergies:		☐ No Known Drug Allergies
Current Medications:		

PRESCRIBER INFORMATION

Prescriber Name:	**NPI:**	
Facility Name:		
Facility Address:		
City:	**State:**	**Zip:**
Phone Number:	**Fax Number:**	
Email:		

PRESCRIPTION AND CLINICAL INFORMATION*

**If required by applicable state law, please attach a copy of prescription on official state prescription form.*

Medication: GRAFAPEX™ (treosulfan) for Injection, for intravenous use

Vial Size and Quantity: (select one or more)
☐ 1g single use vial Quantity (vials): _____
☐ 5g single use vial Quantity (vials): _____

Dosing:
☐ 10 g/m2 by intravenous infusion given daily for three days, beginning on Day -4 prior to transplantation in combination with fludarabine
☐ Other: _____

Patient Height (cm):	**Patient Weight (kg):**	**Patient BSA:**

ICD-10 Diagnosis Code(s):
☐ C92.00 Acute myeloblastic leukemia, not having achieved remission
☐ D46.9 Myelodysplastic syndrome, unspecified
☐ Other(s): _____

HCPCS Code(s):
☐ J0614 Injection, treosulfan, 50mg
☐ Other(s): _____

Site of Administration: ☐ Hospital Inpatient ☐ Hospital Outpatient

I certify that this therapy is medically necessary, and this information is accurate to the best of my knowledge. I certify that I am the physician that has prescribed GRAFAPEX™ to the previously identified patient. I authorize CORE Connections, its partners, and its affiliates on behalf of my patient to facilitate processes to assist the patient in obtaining GRAFAPEX™ as indicated on this prescription.

Prescriber Signature: _____ **Date:** _____

Fax the completed enrollment form and all supporting documents to CORE Connections at (800) 481-3325. Incomplete information may delay the process.

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Patient Name: _____ **Date of Birth:** _____

INSURANCE INFORMATION		
Please submit a copy of the front and back of your insurance card or complete the table below		
	Primary Insurance	**Secondary Insurance**
Plan Name:		
Plan Phone Number:		
Member ID:		
Group Number:		
Policyholder Name:		
☐ **Select if Uninsured**		

FINANCIAL INFORMATION*
**Do not complete this section unless applying for the Patient Assistance Program*
Annual Gross Household Income:
Total Number of People in Household:
Are you a resident of the United States? ◯ Yes ◯ No
CORE Connections may request proof of income such as W2, 1040 Tax Documents, Pay Stubs, SSA-1099.

AUTHORIZED REPRESENTATIVES	
Would you like to authorize a designated person to communicate with CORE Connections on your behalf? ◯ Yes ◯ No	
Representative First Name:	**Representative Last Name:**
Phone Number:	**Email:**
Relationship to Patient:	

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AUTHORIZATION TO DISCLOSE INFORMATION

I authorize CORE Connections to communicate with me or my Authorized Representative (if applicable) regarding my benefits and the program using the following methods. Text and data rates may apply. (select one or more)

☐ Phone ☐ Text Message ☐ Email ☐ US Mail

I authorize CORE Connections to leave a detailed message, including the name of my prescription, if I am unavailable when they call.

◯ Yes ◯ No

I authorize my healthcare provider, my health insurance company, and my pharmacy providers ("Healthcare Entities") to disclose to Medexus Pharma and companies working with Medexus Pharma, which may be branded as CORE Connections™ (collectively, "Medexus Pharma"), my contact information, health information relating to my medical condition to the extent necessary to support treatment that may also include identifying any potential drug interactions evaluation and allergies, and insurance coverage for Medexus Pharma to (i) provide me with support services (which may be branded as CORE Connections™) and related information and materials on any of Medexus Pharma products, including, but not limited to, educational support provided in-person, online or by telephone, financial assistance services, medication adherence services, (ii) conduct data analytics, market research and other internal business activities including, but not limited to, evaluating the services provided, and (iii) provide me with information about Medexus Pharma products, services, and programs and other topics of interest for marketing, educational or other purposes. Once my health information has been disclosed to Medexus Pharma, I understand that Federal privacy laws no longer protect the information and that the information may be subject to further disclosure by Medexus Pharma. However, Medexus Pharma agrees to protect my health information by using and disclosing it only for purposes authorized in this Patient Authorization and Consent or as required by law or regulations. I understand that my pharmacy provider may receive remuneration from Medexus Pharma in exchange for sharing information concerning any services that the pharmacy may provide to me. I understand that I may refuse to sign this Authorization, and I further understand that my treatment (including with a Medexus Pharma product), payment for treatment, insurance enrollment or eligibility for insurance benefits are not conditioned upon my agreement to sign this Authorization. However, if I do not sign this Authorization, or later cancel it, I will not be able to receive any support services from Medexus Pharma including those branded as CORE Connections. I may cancel this Authorization at any time by emailing CORE Connections at coreconnectionscare@pharmacord.com. Canceling this Authorization will end my consent to further disclose health information to Medexus Pharma by my Healthcare Entities after they are notified of my cancellation, but will not affect previous disclosures by them pursuant to this Authorization. Canceling this authorization will not affect my ability to receive treatment, payment for treatment, or my eligibility for health insurance. This Authorization expires three years after the date of signature or such shorter time-frame required by applicable law, from the day I sign it as indicated by the date next to my signature unless otherwise canceled earlier as set forth above.

I have read, understand, and agree to the terms above, Authorization to Disclose Information. I certify that this information is complete and accurate to the best of my knowledge.

Patient Signature: _____ **Date:** _____

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MEDEXUS PHARMA

MP-TREO-0124 November 2025