LIVESTRONG fertility

Criteria and Application
for Women

RETURN COMPLETED FORM
VIA FAX OR EMAIL TO

LIVE**STRONG** Foundation
ATTN LIVE**STRONG** Fertility
FAX *512.309.5515*
EMAIL *Cancer.Navigation@LIVE**STRONG**.org*

EMD Serono

Made possible by participating reproductive endocrinologists and EMD Serono, Inc.

LIVESTRONG® fertility

LIVESTRONG fertility

GOAL

The goal of LIVE**STRONG** Fertility is to increase access to fertility preservation services and treatments for qualified women who are diagnosed with cancer during their reproductive years.

We are proud to offer assistance to qualified female applicants by providing access to fertility medications donated by EMD Serono, Inc. and discounted services from reproductive endocrinologists across the country.

OVERVIEW

LIVE**STRONG** Fertility does not grant direct financial contributions to individuals. Instead, the LIVE**STRONG** Foundation has partnered with key organizations to increase access to procedures and treatments intended to preserve the possibility of fertility for qualified cancer patients whose medical treatments present the risk of infertility and who meet the criteria set forth below.
For a list of participating facilities, please call 855.220.7777.

WHAT IS INCLUDED

LIVE**STRONG** Fertility helps reduce the cost of embryo freezing and egg freezing procedures.

A limited quantity of certain medications prescribed by a reproductive endocrinologist to assist in the development of multiple follicles through ovarian stimulation will be provided through a donation from EMD Serono, Inc. to qualified applicants (see eligibility criteria). Additionally, partnering local reproductive endocrinologists will offer embryo and egg freezing services at a significantly discounted rate. The program includes one embryo freezing or egg freezing procedure and certain medications prescribed by physicians for ovarian stimulation.

WHAT IS NOT INCLUDED

While we understand the importance of other fertility preservation and parenthood options, this program only covers egg and/or embryo freezing. The reduced cost offered by the reproductive center does not include many of the additional costs of preparing for or going through treatment.

THESE ADDITIONAL COSTS COULD INCLUDE, BUT ARE NOT LIMITED TO:

- *Laboratory work performed on your behalf*
- *Anesthesia costs*
- *Doctors' fees*
- *Short-term or long-term storage of frozen eggs or embryos**
- *Implantation procedures*
- *Prenatal care*
- *Travel to fertility clinics*
- *Infectious disease testing*

**Discounts on long-term storage may be available.*

The participant or her insurance company will bear the costs of services provided by entities or individuals not affiliated with LIVE**STRONG** Fertility, including, but not limited to, the costs associated with the related services noted above. It is important to know what those costs are and to plan accordingly.

If a physician determines that treatments or medications other than the services provided by the fertility center are necessary, the participant will be responsible for the cost of such treatments and medications.

This program does not cover the cost of oncology services or any associated expenses incurred during cancer treatments. Keep in mind that neither the Foundation nor EMD Serono are medical providers; all participants acknowledge and agree that neither the Foundation nor EMD Serono shall be liable for any aspect of their current and future treatment. All cancer patients should discuss the risks, side effects, time requirements and other aspects of all treatment options with their physicians before selecting the most appropriate course of care.

*For more information about LIVE**STRONG** Fertility or cancer navigation services at the Foundation, which can help anyone affected by cancer, contact us at 855.220.7777.*

How to Apply

ELIGIBILITY CRITERIA

Applications for this program are reviewed based on the following criteria.
Only patients who meet all of the following criteria will be accepted.

- ☐ *U.S. citizen or permanent resident*
- ☐ *Annual adjusted gross household income is less than or equal to $100,000 (if single) or $135,000 (if married)*
- ☐ *Diagnosis of cancer*
- ☐ *Oncologist has determined that the recommended cancer treatments present the risk of infertility*
- ☐ *Individual has not yet started fertility-damaging cancer treatments*
- ☐ *Oncologist and reproductive endocrinologist have both determined that the treatments and associated medications are medically appropriate*
- ☐ *No contraindication to fertility preservation and/or fertility treatments as determined by an oncologist*
- ☐ *Uninsured or denied insurance coverage for the treatments and procedures required for embryo freezing or egg freezing*
- ☐ *Individual has not previously received benefits from LIVE**STRONG** Fertility*

Please contact us directly for further clarification regarding any of the eligibility requirements listed above.

APPLICATION REQUIREMENTS

Please note your application will not be fully processed if any of the following information has not been received:

- ☐ *Completed Patient Authorization and Consent Form*
- ☐ *Completed Oncologist Referral and Certification Form*
- ☐ *Completed Reproductive Endocrinologist Certification Form*
- ☐ *Copy of your 1040 Federal Tax Return Form from the most recent year*

  If you did not file taxes, contact us at 855.220.7777 for more information.

HOW TO SUBMIT YOUR APPLICATION

Complete the following forms with the help of your medical team and make a copy for your records.
Please print clearly and submit your completed application to the Foundation via mail, fax or email to:

LIVE**STRONG** Foundation
ATTN LIVE**STRONG** Fertility
2201 East Sixth Street Austin, TX 78702
FAX 512.309.5515 EMAIL Cancer.Navigation@LIVE**STRONG**.org

AFTER SUBMITTING YOUR APPLICATION

- » *The Foundation will notify applicants of approval or denial by phone within one–two business days of receipt of all required forms.**
- » *All approved applicants will receive a phone call and an approval letter via email, when possible, to outline the next steps*
- » *The Foundation will facilitate the shipment of medications between the pharmaceutical company and the client.*

** If we have not contacted you within one–two business days of receipt of all required forms, please contact us to verify that your forms have been received. Applications will be closed after six weeks. To reopen your application, you will need to contact the Foundation at 855.220.7777.*

Patient Authorization and Consent Form

Complete all fields in the following form and keep a copy for your records.
Incomplete applications will not be processed.

*Note: You should discuss the risks, side effects and other aspects of all treatment options with your health care team before selecting the best course of treatment for you. If at any time your health care team has advised you or does advise you to seek treatment for cancer immediately, it is the position of the LIVE**STRONG** Foundation that you should not delay your treatments in order to receive these services..*

PERSONAL INFORMATION

LAST NAME FIRST MIDDLE

ADDRESS CITY STATE ZIP

SOCIAL SECURITY DATE OF BIRTH

RACE/ETHNICITY CANCER TYPE

EMAIL PRIMARY PHONE

SECONDARY PHONE

☐ *I give the LIVE**STRONG** Foundation permission to speak with another party regarding my LIVE**STRONG** Fertility application (e.g., parent/guardian, significant other, friend).*

☐ *I am a minor or have a secondary contact managing my application for medical or personal reasons. I understand the Foundation will contact my secondary contact first.*

NAME RELATION PRIMARY PHONE

EMAIL ADDDRESS

INSURANCE INFORMATION

COMPANY NAME GROUP NUMBER POLICY NUMBER

TELEPHONE NUMBER

☐ *Uninsured*

FINANCIAL INFORMATION

Average three-year annual household income

I certify that my yearly income or three-year income average is:

☐ *Equal to or less than $100,000 (for single applicants)*

☐ *Equal to or less than $135,000 (for married applicants)*

CONFIRM

☐ *I have included my 1040 Federal Tax Return Form from the most recent year with this application. When speaking to the IRS, all references to LIVE**STRONG** Fertility should be made by stating that they are services administered by the LIVE**STRONG** Foundation.*

☐ *I am currently unemployed and have been unemployed for a consecutive period of six (6) months prior to the date of this application. If I cannot provide sufficient proof of unemployment by copy of my most recent unemployment benefit claims statement or payment, I authorize the LIVE**STRONG** Foundation to reasonably verify my unemployment status as part of the income verification process for the purposes of this application only.*

Patient Authorization and Consent Form

APPLICANT CERTIFICATION AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I certify that all of the information provided in this application is complete and accurate. I authorize the release of the information contained in this application. I understand it is for the sole use of the LIVE**STRONG** Foundation, its program participants, its representatives and/or agents (collectively, "the Foundation") in order to assess my eligibility for participation in LIVE**STRONG** Fertility. I authorize the Foundation to request and obtain from my physicians and any insurer any medical or other patient information related to my treatment for cancer and infertility. I authorize the Foundation to share the information contained herein with EMD Serono, Inc., the pharmacy that will dispense my fertility medication to me (the "Pharmacy") and participating fertility centers in connection with LIVE**STRONG** Fertility. I agree to immediately inform the Foundation if my income or insurance status changes and to provide any documentation that the Foundation requests to verify the same. I authorize the Foundation to contact me directly to process this application. I understand that my application for assistance does not guarantee that assistance will be provided. I understand that eligibility for LIVE**STRONG** Fertility is subject to approval under the criteria and requirements set forth herein and that the Foundation reserves the right to change or terminate LIVE**STRONG** Fertility without prior notice. I agree to abide by this certification and authorization during my participation in LIVE**STRONG** Fertility and to notify the Foundation if aspects of my application, certification or authorization are no longer applicable.

I understand that neither the Foundation, nor EMD Serono, Inc. nor the Pharmacy are medical providers, and by submitting this application with my signature below, I acknowledge and agree that neither the Foundation, nor EMD Serono, Inc. nor the Pharmacy shall be liable for any aspect of my current and future treatment. I understand that there are no guarantees that the procedures intended to assist in preserving fertility or the associated medications that may be provided to me under LIVE**STRONG** Fertility will be successful in preserving my fertility. I understand the success rates of the procedures, and I agree that neither the Foundation, nor EMD Serono, Inc. nor the Pharmacy shall be liable for any treatment failure.

I assume all risk of and financial responsibility for any loss or injury related directly or indirectly to my participation in LIVE**STRONG** Fertility and agree to indemnify and hold the Foundation, EMD Serono, Inc. and the Pharmacy harmless from and against any and all costs, claims, demands, charges, liabilities, obligations or fees incurred or suffered by me as a result of, or arising out of, my participation in LIVE**STRONG** Fertility except for claims resulting wholly from the gross negligence of the Foundation, EMD Serono, Inc. or the Pharmacy.

I understand that if I qualify for LIVE**STRONG** Fertility, I may receive a limited quantity of certain medications from EMD Serono, Inc. that my physician may prescribe in connection with one embryo freezing procedure or one egg freezing procedure. I understand that if I receive such medications, EMD Serono, Inc. is under no obligation to provide me with additional medications.

I have discussed with my physicians the risks, side effects and other aspects of all treatment options before selecting a course of treatment for me.

I understand that the Foundation is authorized as a "business associate" under 45 CFR 160.103 (in the act commonly known as "HIPAA") and that as a business associate, health providers are allowed to disclose my protected health information to the Foundation based on the written assurances made by the Foundation to the health provider that the information will only be used for the purposes of LIVE**STRONG** Fertility, that the information will be safeguarded from misuse, and that the Foundation will help the health provider comply with their HIPAA duties.

By signing below, I certify that I have completely and accurately disclosed, and at all times will completely and accurately disclose, my medical history to all of my health care providers, including but not limited to, any oncologist or reproductive endocrinologist. I understand that the agreements under LIVE**STRONG** Fertility shall be construed and interpreted in accordance with the laws of the State of Texas without regard to its conflicts of law provisions.

PATIENT SIGNATURE _____ DATE _____

PARENT/GUARDIAN SIGNATURE _____ DATE _____

(If patient is under age 18)

Oncologist Referral and Certification Form

Complete all fields in the following form and keep a copy for your records.
Incomplete applications will not be processed.

*Note: You should discuss the risks, side effects and other aspects of all treatment options with your patient before recommending the best course of treatment. If at any time you have advised or do advise your patient to seek treatment for cancer immediately, it is the position of the LIVE**STRONG** Foundation that the patient should not delay treatments in order to receive these services.*

PATIENT INFORMATION

LAST NAME | FIRST | MIDDLE

DOB | PRIMARY PHONE

PHYSICIAN INFORMATION

LAST NAME | FIRST | MI | TITLE

DEA/NPI NUMBER | CLINIC/HOSPITAL

STREET ADDRESS | CITY | STATE | ZIP CODE

PHONE | FAX | EMAIL

NURSE OR CLINIC CONTACT NAME (IF DIFFERENT FROM PHYSICIAN)

PHONE | FAX | EMAIL

TREATMENT INFORMATION

CANCER TYPE

TREATMENT PLAN *(check all that apply)*

- ☐ *Surgery to the reproductive area, explain*
- ☐ *Radiation to the brain or reproductive area*
- ☐ *Chemotherapy*
- ☐ *Other, explain*

TREATMENT TIMELINE

(should fall after completion of fertility treatment)

ESTIMATED START DATE | ESTIMATED TREATMENT DURATION

FOR THE FOLLOWING TWO QUESTIONS, CHECK YES OR NO.

Answers are required for both questions; incomplete answers will delay processing.

Does your intended treatment plan present a risk that the patient may become infertile?

☐ *Yes* ☐ *No*

Are there any known medical contraindications to the above-named patient undergoing fertility preservation treatments and the associated risks and side effects?

☐ *Yes* ☐ *No*

*I have discussed with the patient the risks, side effects and other aspects of all her treatment options. I certify that I have read the full physician prescribing information for each of the EMD Serono, Inc. products that may be prescribed by a reproductive endocrinologist under this program (Gonal-f®, Ovidrel® PreFilled Syringe, Cetrotide® 0.25mg) and that: the use of such medications for the above-named patient is consistent with each product's labeling, and in my medical judgment there is no reason that the above-named patient should not be treated with any one or more of these medications. Neither the LIVE**STRONG** Foundation nor EMD Serono, Inc. is a medical provider, and I acknowledge and agree that neither the Foundation nor EMD Serono, Inc. shall be liable for any aspect of the treatment of the patient I have referred to the Foundation for participation in LIVE**STRONG** Fertility.*

ONCOLOGIST SIGNATURE | DATE

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Reproductive Endocrinologist Certification Form

Complete all fields in the following form and keep a copy for your records.
Incomplete applications will not be processed.

*Note: You should discuss the risks, side effects and other aspects of all treatment options with your patient before recommending the best course of treatment. If at any time you have advised or do advise your patient to seek treatment for cancer immediately, it is the position of the LIVE**STRONG** Foundation that the patient should not delay treatments in order to receive these services.*

PATIENT INFORMATION

LAST NAME | FIRST | MIDDLE

DOB | PRIMARY PHONE | CANCER TYPE

SHIPPING ADDRESS | CITY | STATE | ZIP CODE

ALLERGIES | SECONDARY PHONE | EMAIL

PHYSICIAN INFORMATION

LAST NAME | FIRST | MI | TITLE

DEA/NPI # | CLINIC/HOSPITAL

STREET ADDRESS | CITY | STATE | ZIP CODE

PHONE | FAX | EMAIL

IVF NURSE COORDINATOR

PHONE | FAX | EMAIL

TREATMENT PLAN

☐ *Embryo Freezing* ☐ *Egg Freezing*

ANTICIPATED START DATE:

INSURANCE COVERAGE

The patient listed above has been denied insurance coverage for the treatments and procedures required for the above-noted treatment plan.

A PER PATIENT MAXIMUM OF 2,700 IUS FOR GONAL-F AVAILABLE PRESENTATIONS INCLUDE:

☐	GONAL-F RFF 75 IU	_____VIALS	SIG_____	0 REFILLS
☐	GONAL-F RFF REDI-JECT 300 IU	_____PENS	SIG_____	0 REFILLS
☐	GONAL-F RFF REDI-JECT 450 IU	_____PENS	SIG_____	0 REFILLS
☐	GONAL-F RFF REDI-JECT 900 IU	_____PENS	SIG_____	0 REFILLS
☐	MULTI-DOSE GONAL-F 450 IU	_____VIALS	SIG_____	0 REFILLS
☐	MULTI-DOSE GONAL-F 1050 IU	_____VIALS	SIG_____	0 REFILLS

MAXIMUM OF 5 BOXES OF 0.25MG PER PATIENT

☐	CETROTIDE 0.25 MG	_____BOXES	0 REFILLS

MAXIMUM OF 1 SYRINGE PER PATIENT

☐	OVIDREL 250MG	_____SYRINGE	0 REFILLS
☐	SHARPS PACKAGE – SHARPS DISPOSAL UNIT, ALCOHOL WIPES, GAUZE, DISPOSAL INSTRUCTIONS, ETC		

Package inserts for EMD Serono Inc.'s U.S. marketed products are available at emdserono.com or by calling 888.275.7376.

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*I have also explained to her that there are no guarantees that the procedure or associated medications provided to her under LIVE**STRONG** Fertility will be successful in her effort to conceive using her own eggs. I have discussed success rates of the procedures with the above-referenced patient and agree to undertake the procedure in accordance with good clinical practice, including but not limited to any applicable guidelines issued by the American Society for Reproductive Medicine or other similar professional organizations. I understand that any medications provided to me through LIVE**STRONG** Fertility must be provided only to the above-namedpatient and are not for trade, sale or purchase. I agree that I will not seek reimbursement by any federal, state or private program for any of the medications provided to the above-named patient under LIVE**STRONG** Fertility*

REPRODUCTIVE ENDOCRINOLOGIST SIGNATURE | DATE

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