Welcome to the ZySupport Patient Service Program

ZySupport
Patient Services

Your single source for access and affordability for Zydus USA products



zydussupport.com

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ZySupport: With You at Every Step

We understand the healthcare process can be challenging. Because of that, our reimbursement experts are available from 8am-8pm ET to answer questions regarding coverage, prior authorization, appeals, co-pay support, and more to help patients start and stay on their prescribed Zydus medicines - regardless of insurance type.

ZySupport offers a full suite of solutions to address common hurdles to access and reimbursement such as:

- Benefits verification for patient coverage and out of pocket responsibilities
- Payer-specific guidance for prior authorizations & appeals to address patient needs
- Solutions for insurance-related delays

*Patients must express need and meet certain eligibility requirements

Coverage and Access Assistance

Educational Resources

Prior Authorization Requirements

Financial Support Options

Co-pay Assistance



Getting Started With ZySupport is Easy

Phone

866-891-9938

Mon-Fri 8am-8pm ET

Upon your request, one of our support specialists will guide you through the process.

Online

Visit us at:

zydussupport.com

Fax

Download, print, and fax the completed enrollment form to:

703-738-7254

Multilingual Support Available

We offer support in Spanish, and can arrange interpretation services for other languages on request.

When your doctor is enrolling you in ZySupport, you may need to provide the following information:

- Personal information, including home address and phone number
- Insurance information, including the type of insurance you have (e.g. employer based, Medicaid, Medicare, etc.), policy number, group number and policyholder name
- Secondary insurance and prescription insurance coverage information, if applicable



Enrollment Form

ZySupport
Toll-Free: 866-891-9938 (Mon-Fri 8am - 8pm EST)
Fax: 703-738-7254
www.zydussupport.com

ZySupport Patient Services

Support requested (check all that apply) * Required Field

☐ Insurance Verification — Benefit Investigation, Prior Authorization, Appeal Assistance
☐ Free Product Assistance (PAP) (uninsured/underinsured)
☐ Bridge Supply (coverage delays)

Select Medication *

☐ Bezray™ (docetaxel) injection, for intravenous use

Patient Information

First Name *_____ Last Name *_____ Date of Birth *_____ Male ☐ Female ☐
Height *_____ Weight *_____ Phone # *_____
Address *_____ City *_____ State *_____ Zip *_____
Alt. Contact First Name _____ Alt. Contact Last Name _____
Alt. Contact Relationship _____ Alt. Contact Phone # _____

Prescriber/Facility Information

First Name *_____ Last Name *_____ State Where Licensed *_____
State License # *_____ Prescriber Type *_____ NPI # *_____
Tax ID # *_____ PTAN# *_____
Facility Name *_____
Facility Address *_____ City *_____ State *_____ Zip *_____
Primary Contact Name *_____ Title/Role _____
Primary Phone # *_____ Primary Fax # *_____
Primary Email _____
Facility Information/Billing Entity: ☐ Infusion Clinic/Physician Office ☐ Hospital Outpatient ☐ Hospital Inpatient

**By submitting this form, I am requesting support services on behalf of the patient. Certain eligibility criteria and restrictions apply.

Please see full Prescribing Information including Boxed Warning, at the QR code

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Zydus and its agents make no guarantee regarding reimbursement for any service or item. The accurate completion of reimbursement- or coverage-related documentation is the responsibility of the healthcare provider and patient. For eligibility requirements, please contact a patient assistance specialist.

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Dedicated To Life