PAXMAN HUB ENROLLMENT FORM

PLEASE NOTE: HCP MUST HAVE A CONTRACT WITH PAXMAN TO PRESCRIBE FOR THIS SERVICE.

coldcap.com

PAXMAN HUB

PAXMAN HUB
PO BOX 29264
PHOENIX AZ 85038-9264
PHONE: 8445PAXMAN
FAX: 888-358-0410

Financial Assistance Requested: Yes No
Financial Assistance Approved: Yes No
Foundation Name:.....

Insurance Data (Optional-For Data Collection Purposes Only)
Insurance Name:.....
Insurance Phone:.....
Policy:.....
Group:.....
Policy Holder's Name:.....
Policy Holder's DOB:.....
Policy Holder's SSN:.....

PLEASE COMPLETE THE INFORMATION BELOW AND FAX TO **888-358-0410**

STEP 1 PATIENT INFORMATION (*Required Fields)

First Name*: | MI: | Last Name*: | DOB*: (/ /)

Address*:

City*: | State: | Zip:

Gender: M F

Ethnicity:
(Select only one box)
Hispanic or Latino
Not Hispanic or Latino

Race: (Select all applicable)
White
Asian
Black or African American
American Indian or Alaska Native
Native Hawaiian or Other Pacific Islander

Home Phone Number*:

Cell Phone Number*:

Preferred Number to Call: Home Phone Cell Phone

Email Address:
Tick box to opt-out of receiving educational and marketing material:

STEP 2 PRESCRIBER/PHYSICIAN INFORMATION (*Required Fields)

Prescriber/Physician First Name*: | Prescriber/Physician Information Last Name*:

Facility/Practice Name*:

Practice Address*:

City*: | State*: | Zip*:

NPI #: | State License #:

Practice Contact First and Last Name:

Practice Contact Email Address: Tick box to opt-out of receiving educational and marketing material:

Practice Contact Phone #*: | Practice Contact Fax #*:

Prescriber/Physician Email Address: Tick box to opt-out of receiving educational and marketing material:

PATIENT CONSENT IS ALSO MANDATORY FOR PROCESSING (*Required Fields)

I authorize my health care providers, pharmacies, and health insurer(s) to disclose my personal information, including information about my insurance, prescriptions, medical condition and health ("Personal Information") to Paxman, its affiliates, business partners, service providers, third-party contractors, and agents (together, the Paxman Hub) so that the Paxman Hub can provide me with the Patient Support Services available for the Paxman Scalp Cooling Cap prescribed by my HCP on this Enrollment Form to (i) help to verify or coordinate insurance coverage or otherwise obtain payment for my treatment with this product including to locate alternative funding sources , (ii) coordinate my receipt of, and payment for this product, (iii) facilitate my access to this product, (iv) provide me with information about this product and management programs and educational materials, (v) manage the Patient Support Services, (vi) provide me with adherence reminders and support, and (vii) conduct quality assurance, surveys, and other internal business activities in connection with the Patient Support Services. I give permission to the Paxman Hub to disclose my Personal Information to my health care providers, pharmacies, health insurer(s), caregivers, and other third-party contractors or service providers for the purposes described above.

I understand that my pharmacy, health insurer(s), and health care providers may receive remuneration (payment) from Paxman in exchange for disclosing my Personal Information to Paxman and/or for providing me with therapy support services. I understand that once my Personal Information is disclosed it may no longer be protected by federal privacy law. I understand that I can refuse to sign this Authorization and that this will not affect my treatment, insurance coverage, or eligibility for benefits or Paxman products; however, if I do not sign this Authorization, I will not be able to receive Patient Support Services. I also may revoke this authorization at any time in the future by writing to PO Box 29264, Phoenix, AZ 85038-9264. If I revoke this authorization, I may no longer be eligible to participate in the Patient Support Services. If I revoke this authorization, the Paxman Hub will stop using or sharing my information (except as necessary to end my participation in the Services) but my revocation will not affect uses and disclosures of my Personal Information previously disclosed in reliance upon this authorization. I understand that this authorization will remain valid for five years after the date of my signature, unless I revoke it earlier. I also understand that the Patient Support Services may change or end at any time without prior notification. I understand that I have the right to receive a copy of this form.

Patient Signature*: | Date:

I appoint the person named below to act as a representative for me and/or my minor child. I authorize the representative to receive, discuss, and disclose my personal information. This authorization does not give the representative authority over treatment or direct-care decisions.

Name: | Contact Number(s):

Relationship to Patient:

PAXMAN HUB ENROLLMENT FORM

Patient Full Name* | **Patient DOB*** | **Prescriber/Physician Name*** | **NPI#***

STEP 3 TREATMENT AND PRESCRIPTION INFORMATION AND PRESCRIBER/PHYSICIAN AUTHORIZATION

ICD-10 Diagnosis Code*:

Additional Diagnosis Code:

Additional Diagnosis Code L65.9:

Therapy Start Date:

Directions: **Use as directed**

Quantity: **One**

Cap/Cover Size (REQUIRED for New Patients only)*: ☐ S/S ☐ M/S (Medium cap/inner, Small cover/outer) ☐ M/M ☐ L/L

Prescribed Treatment Days*: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12

Other No. of Treatment Days:

☐ Refill (check corresponding treatment days needed. Do not include initial treatment days received)

Date of Refill: Refill Treatment Days ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12

Date of Refill: Refill Treatment Days ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12

Date of Refill: Refill Treatment Days ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12

☐ Refill (if more than treatment days is needed, check corresponding treatment day below)

Date of Refill: Refill Treatment Days ☐ 13 ☐ 14 ☐ 15 ☐ 16 ☐ 17 ☐ 18 ☐ 19 ☐ 20 ☐ 21 ☐ 22 ☐ 23

Date of Refill: Refill Treatment Days ☐ 13 ☐ 14 ☐ 15 ☐ 16 ☐ 17 ☐ 18 ☐ 19 ☐ 20 ☐ 21 ☐ 22 ☐ 23

Date of Refill: Refill Treatment Days ☐ 13 ☐ 14 ☐ 15 ☐ 16 ☐ 17 ☐ 18 ☐ 19 ☐ 20 ☐ 21 ☐ 22 ☐ 23

☐ Refund (check completed treatment days)

Completed Treatment Days: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12

PRESCRIBER/PHYSICIAN AUTHORIZATION – MANDATORY FOR PROCESSING

I certify that (i) the information contained on this form is accurate to the best of my knowledge and (ii). I am the prescribing healthcare provider of Paxman Scalp Cooling Cap to the previously identified patient and that I provided the patient with the description of the Paxman program. For purposes of transmitting this prescription, I authorize Paxman US, Inc. and its affiliates, business partners, and agents, to forward as my agent for these limited purposes, this prescription electronically, by facsimile, or by mail to a dispensing pharmacy.

Dispense as Written: *If this form does not meet your state's requirements for a valid prescription, please attach a valid prescription (or eprescribe).*

Prescriber Signature*: Date:

CAP/COVER SIZE SWAP

In the event that the patient determines a different cap size is required after taking delivery, physician is required to check the box for new size required, re-sign below and re-fax to Paxman Hub on 888-358-0410.

☐ S/S ☐ M/S (Medium cap/inner, Small cover/outer) ☐ M/M ☐ L/L

Prescriber Signature*: Date:

(*Required Fields)

PAXMAN HUB PROCESSING TIME

HUB STANDARD PROCESSING TIME (3 – 5 BUSINESS DAYS)

Day 1: Enrollment form completed and faxed to Paxman Hub 888-358-0410
Day 2: Paxman Hub reach out to patient for payment within 24-48 hours; once successfully taken Rx is sent to Pharmacy
Day 3-4: Cap is dispatched - Patient must be available via phone to schedule shipment with Pharmacy before it is dispatched
Note: Standard processing at the Pharmacy 24-48 hours. We strive to work all cap orders ASAP.
Day 4-5: Cap is received (unless patient requests a future delivery date)

HUB URGENT PROCESSING TIME

Day 1: Enrollment form completed and faxed to Paxman Hub 888-358-0410
Day 1: Paxman Hub reach out for payment; once successfully taken Rx is sent to pharmacy
Day 1: Cap is dispatched - ONLY if Rx is received by Pharmacy by 4pm EST/3pm CST/1pm MST/12pm PST
Patient must be available via phone to schedule shipment with pharmacy before it is dispatched
Note: HUB will notify Pharmacy the case is urgent.
Day 2: Cap is received

URGENT CASE: DAY 1 ACTIONS

- Patient enrols and is sized for cap at HCP
- Enrollment form faxed to Paxman Hub 888-358-0410
- Paxman Hub checks for accuracy
- If all in order, Hub reach out to patient to take payment
- Paxman Hub fax enrollment form to Pharmacy
- Pharmacy reach out to patient to confirm shipping
- Pharmacy ship cap - ONLY if Rx is received by Pharmacy by 4pm EST/3pm CST/1pm MST/12pm PST
  Note: HUB will notify Pharmacy the case as urgent.

PLEASE NOTE:

Inaccuracies or incomplete information on Enrollment Form WILL lead to processing delays – please ensure ALL boxes are checked and prescriber signature is obtained.

All relevant fields to be completed however fields marked with an * MUST be completed to generate a prescription:

- Patient name
- Patient address or DOB
- Physician information
- Date
- Original signature from licensed physician

Note: in states that allow Physician Assistants and Nurse Practitioners to write prescriptions, we will also need the name of the supervising physician.

NOTE FOR PATIENT:

Paxman Hub will attempt to contact you on the number provided to take payment, if applicable, which will be followed up by a call from Pharmacy for cap shipment scheduling. Please note that the call may be from an unlisted/unregistered number so please be mindful of this and try to be available to answer these calls wherever possible.

Standard processing: Three call attempts are made within 5 business days.

Urgent processing: Pharmacy will attempt to make an outreach call to patient and leave a voicemail if there is no answer. The HUB will then be notified and make additional outreach attempt to patient, and also leave a voicemail if unreachable. Both teams will follow up the following day if there has not been a response received.

Please feel free to call the Paxman Hub on 844 572 9626 to confirm receipt of complete and accurate Enrollment Form once this has been faxed.

PAXMAN
PERSONAL CAP KIT

This document sets out the terms under which Paxman US, Inc. makes available the Paxman Personal Cap Kit ("Kit") to you.

Please Note:

Caps are not eligible for refund.

Treatment 1 is not eligible for a refund unless requested prior to cap kit shipping

If you decide not to proceed with scalp cooling before any treatment

If you have ordered the Kit but you decide before receiving it that you do not wish to proceed with scalp cooling, we ask that you do not open the Kit once you receive it or, if you have opened it, please do not use it any further.

We are able to give you a refund but we require you to return the Kit to us. In this case, please call 888-572-9626 or email patient@paxmanUSA.com so that we can organize a pre-paid return shipping label to be sent to you.

We require the Kit to be received by us before we will organize the refund. We will refund you by the method you used for payment and the amount of the refund will be the amount you paid less a restocking fee of $200.00.

If you decide not to proceed with scalp cooling after treatment has started

If you wish to stop treatment after you have started the sessions, you are free to do so. You will be entitled to a refund for any complete treatments that you have not taken.

It will be necessary for your physician to complete the Enrollment Form to inform Paxman US, Inc. of the number of treatments that you have not taken. We do not require the Cap to be returned to us before we can process a refund. If you do wish to return your Cap, please call 888-572-9626 or email patient@paxmanUSA.com so that we can organize a pre-paid return shipping label to be sent to you so that you can return the Cap to us. Returned Caps will be added to our Cap Recycle Program.

Once we have received the completed Enrollment Form, we will refund the amount due to you for the number of treatments you will not be taking, the refund being by the method you used for payment.

The Cap

The Cap is prescription-only and, as such, is personal to you. You should not transfer it to anyone else.

While you will have been through the sizing process with your physician prior to ordering your Kit, it is possible that you need a different size following receipt of your Cap or it may be that the size of Cap needed may change marginally during the course of the treatments. If you need a change in Cap size, speak with your physician or one of the healthcare team members at your treatment center first to check that this is appropriate. If they agree, please call 888-572-9626 or email patient@paxmanUSA.com so that we can send out a new size of Cap to you. We will send it with a pre-paid return shipping label so that you can return the current Cap to us.

The Cap is quite resistant to damage and any damage is unlikely. However, if the Cap is damaged prior to receipt by you or during your treatment, please call 888-572-9626 or email patient@paxmanUSA.com to inform us and we will replace it. We will send out a pre-paid return shipping label at the same time as sending the replacement Cap. Please return the damaged Cap to us as soon as possible.

It is your responsibility to maintain the condition of the Cap and therefore, after each use of the Cap, you will need to clean it. The steps to follow for effective cleaning can be found in our literature.

At the end of your treatment

At the end of your treatment, you are welcome to keep your Cap. If you do need to repeat chemotherapy in the future and need to use the Cap again, we can send you a new token for use at your treatment center. You will need to complete a new Enrollment Form with your physician prior to treatment.

However, Paxman is able to recycle Caps for use with certain patients who may qualify for assistance from Paxman. If you would like to assist someone else in this way, please let us know by calling 888-572-9626 or email patient@paxmanUSA.com and we will send a pre-paid return shipping label to you so that you can return your Cap to us.

General

1. It is important that you follow the instructions of the healthcare team member that is assisting you during your treatment.
2. You will need to wear the Cap for the appropriate time before and after treatment, as well as during the treatment itself. More information about treatment sessions and preparing your hair prior to treatment can be found in our tutorial videos that can be found on our website - **www.coldcap.com/support-guidance/tutorial-videos** or in our Patient Brochure which can be found here - **www.coldcap.com/downloads-us**
3. With regard to the shipping of the Kit or of any replacement Caps to you as referred to above, we shall not be responsible or liable for any delays or the effect of any delays arising from events which are out of our control. This includes but isn't limited to any natural disaster or similar weather-related event, delays caused by or affecting our delivery partners or non-performance by suppliers or subcontractors.
4. We need to remind you that:

- hair loss is a possible side effect of chemotherapy
- the treatment success rates with the Paxman Scalp Cooling System vary from patient to patient and with different drug regimens being administered.
- we cannot guarantee that you will not lose any or all of your hair

5. With regard to the treatments, the following may also arise:

- you may experience a headache during treatment
- it is possible that you may feel cold during treatment
- it is also possible that you may feel lightheaded after the Cap has been removed. You should give yourself a few minutes to adjust before leaving the treatment center.