Heron Connect® Enrollment Form

This form should be used to enroll patients receiving ZYNRELEF into Heron Connect for insurance verification. To enroll a patient, please complete and submit the enrollment form by faxing it to 1-844-504-8652. Heron Connect can be reached at 1-844-437-6611 to answer general questions, 8 AM to 8 PM ET, Monday through Friday, or visit HeronConnect.com.

HERON CONNECT®

ZYNRELEF™
(bupivacaine and meloxicam)
extended-release solution
29.25 mg/mL and 0.88 mg/mL

1. Prescribing Physician Information (Required)

Physician's Name: _____ Address: _____

Practice/Facility Name: _____ City: _____ State: _____ ZIP: _____

Physician's Specialty: _____ Telephone: _____

Physician's State License #: _____ Fax: _____

Physician's Tax ID #: _____ Email: _____

Prescriber's National Provider Identifier (NPI) #: _____ Site's National Provider Identifier (NPI) #: _____

Site Contact: _____ Telephone: _____ Email: _____

Physician signature required on other side of this document to complete enrollment.

2. Patient Information and Insurance Information (Required)

Patient's Name: _____ Preferred Phone: _____

Address: _____ Email: _____

City: _____ State: _____ ZIP: _____ Date of Birth: _____

Gender: ☐ Male ☐ Female

Attach a copy of the insurance card (front AND back) OR complete insurance information below:

Primary Insurance: _____ Secondary Insurance: _____

Primary Insured's Name: _____ Secondary Insured's Name: _____

Employer: _____ Employer: _____

Phone: _____ Phone: _____

Policy #: _____ Policy #: _____

Group #: _____ Group #: _____

Health Plan Name: _____ Health Plan Name: _____

3. Patient Treatment Information

Patient's Primary Diagnosis (ICD-10): _____ Patient's Secondary Diagnosis (ICD-10): _____

Surgical Procedure: _____ Date of Surgery: _____

Site of Surgery: ☐ Hospital (inpatient) ☐ Hospital (outpatient) ☐ Ambulatory Surgery Center ☐ Physician's Office

Physician Signature Required on Reverse Side

Please see full Prescribing Information, including Boxed Warning.

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4. Physician Enrollment Certification (Required)

I verify that the information provided in this enrollment form is complete and accurate to the best of my knowledge. I have obtained my patient's authorization to disclose his/her health information related to treatment with ZYNRELEF to Lash Group, a designated agent for Heron Therapeutics. I certify that the patient named above has authorized the release and disclosure of the information contained within this enrollment form for the purposes of investigating and resolving insurance, coding, or reimbursement questions.

☐ By checking this box, I attest that I have received authorization from the patient named on this enrollment form to sign, on the patient's behalf, the **Patient Authorization and Release for Use/Disclosure of Health Information** for enrollment into Heron Connect.

☐ I do NOT have the patient's consent.

I understand that Heron Therapeutics may revise, change, or terminate this program at any time. By signing below, I represent that ***I am the prescriber or that I have the appropriate authority to sign*** on behalf of the prescriber and/or the practice listed on this form.

Physician or Provider Contact:

Signature X _____ **Date:** _____

PATIENT AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION (MAY BE REQUIRED)

This section must be completed by the patient if the Physician or Provider Contact indicates in the section above that the patient has not authorized the Physician or Provider Contact to sign the Patient Authorization and Release for Use/Disclosure of Health Information or enroll in Heron Connect or its programs on the patient's behalf.

I authorize my prescribing physician and any health insurers, plan, or programs that provide me healthcare benefits (collectively, "Health Plans") to disclose my medical or other information, including information about my treatment with ZYNRELEF (taken together, "information") and related medical condition to Lash Group, as an agent of Heron Therapeutics, for the use and disclosure of such information for the following specific purposes: conducting reimbursement verification and coverage under my Health Plans; offering direction for appeal of a denial of coverage by my Health Plans. I give my permission for Lash Group to contact me if necessary. I understand that, once my information has been disclosed, federal and state privacy laws may no longer protect it. However, the recipients of such information agree to protect my information by using it only for the purposes authorized in this Authorization or as permitted by law. I understand that signing this Authorization is voluntary and, if I do not sign this Authorization, it will not affect my ability to obtain treatment from my prescribing physician or obtain insurance or insurance benefits. I may withdraw this Authorization at any time by calling 1-844-437-6611. Withdrawal of this Authorization will end further uses and disclosures of my information by the parties identified in this Authorization, except to the extent those uses and disclosures have been made in reliance upon this Authorization and as permitted by applicable law. This Authorization expires 10 years from the date indicated below unless I withdraw it earlier. I am entitled to receive a copy of this Authorization.

Patient or Legal Authorized Representative: X _____ **Date:** _____

Full Name (please print): _____ **Year of Birth:** _____

Please see full Prescribing Information, including Boxed Warning.

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HeronConnect.com