



**SYFOVRE**<sup>®</sup>  
(pegcetacoplan injection)  
15 mg / 0.1 mL

# Access and Reimbursement Guide

## A step-by-step guide to help support patient access to SYFOVRE

This guide is intended to provide information about access and reimbursement for SYFOVRE but is not meant in any way to provide a guarantee of coverage or reimbursement for any product or services. Coding and coverage policies change periodically, often without warning. The responsibility to determine coverage and reimbursement parameters and appropriate coding for a particular patient or procedure is always the responsibility of the provider. Providers should exercise independent clinical judgment when selecting codes and submitting claims to accurately reflect the services and products furnished to a specific patient. Practices should contact the applicable payer for more information on a payer's coverage, coding, and reimbursement policies.

ApellisAssist<sup>™</sup> **Here for your patients**

Phone: **888-APELLIS** (888-273-5547) 8 AM-8 PM ET, Monday-Friday

Website: **SyfovreECP.com**

Portal: **ApellisAssistGA.com**

Fax: **888-405-6966**

### INDICATION

SYFOVRE<sup>®</sup> (pegcetacoplan injection) is indicated for the treatment of geographic atrophy (GA) secondary to age-related macular degeneration (AMD).

### IMPORTANT SAFETY INFORMATION

#### CONTRAINDICATIONS

- SYFOVRE is contraindicated in patients with ocular or periocular infections, and in patients with active intraocular inflammation

Please see additional Important Safety Information throughout and the full [Prescribing Information](#).

Apellis

# How to use this guide

In this guide, you will find an overview of access and reimbursement support services for SYFOVRE, including links to educational resources. Please click on the numbers below to learn more about each topic.

## Overview of the access and reimbursement process

### Before injection

#### 1 Learn about available access and reimbursement support offered by Apellis FRMs and the ApellisAssist® program

- Get to know your FRM (Field Reimbursement Manager)
- Get to know the ApellisAssist program

#### 2 Enroll your patient in the ApellisAssist program

- Once you decide SYFOVRE is right for your patient, enroll them online or via fax to start the benefits investigation process
- Register for the portal and submit your request online at [ApellisAssistGA.com](https://ApellisAssistGA.com)

OR

- Download the **Enrollment Form** at [SyfovreECP.com](https://SyfovreECP.com) and fax the completed form to 888-405-6966

#### 3 Review insurance coverage information

Review the Summary of Benefits provided by the ApellisAssist program to determine insurance requirements.

#### 4 Obtain prior authorization (PA) (if required)

If the benefits investigation demonstrates that a PA is required, submit the PA and **Letter of Medical Necessity** (LMN) to the health plan.



A sample LMN can be downloaded at [SyfovreECP.com](https://SyfovreECP.com)

#### 5 Understand patient financial assistance eligibility

ApellisAssist will notify your office and patient of financial assistance eligibility.

#### 6 Confirm product acquisition method

Determine buy and bill or specialty pharmacy acquisition method and order the product.



The **Product Ordering Guide** can be downloaded at [SyfovreECP.com](https://SyfovreECP.com)

### After injection

#### 7 Submit the claim

Ensure information on the claim form is accurate and complete.



The **Billing and Coding Guide** can be downloaded at [SyfovreECP.com](https://SyfovreECP.com)

#### 8 Understand and manage reimbursement

Understand reimbursement processes for your practice. Track claims and ensure appropriate payment is received.

#### 9 Appeal denied claims

If you receive a denied claim for a patient who is enrolled in the ApellisAssist program, then ApellisAssist and the FRM can work with you to help determine the denial reason and provide information about the steps you should take to appeal.



A sample **Appeals Letter** can be downloaded at [SyfovreECP.com](https://SyfovreECP.com)

#### 10 Prepare for PA reauthorization (if applicable)

ApellisAssist can help determine if your patient's health plan requires reauthorization for SYFOVRE.

## IMPORTANT SAFETY INFORMATION (cont'd)

### WARNINGS AND PRECAUTIONS

#### • Endophthalmitis and Retinal Detachments

- Intravitreal injections, including those with SYFOVRE, may be associated with endophthalmitis and retinal detachments. Proper aseptic injection technique must always be used when administering SYFOVRE to minimize the risk of endophthalmitis. Patients should be instructed to report any symptoms suggestive of endophthalmitis or retinal detachment without delay and should be managed appropriately.



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# Step 1: Get to know your Field Reimbursement Manager

Your FRM can help support patient access



## Access and reimbursement information about SYFOVRE

- Provide information about payer coverage, PA processes, and billing and coding
- Share regional payer trends and policy updates



## Product acquisition and procurement

- Explain policies and processes related to product acquisition
- Share contact details for our distribution network



## Patient support services education

- Walk through ApellisAssist patient support services and how to access support
- Share information about financial assistance options for eligible patients

## IMPORTANT SAFETY INFORMATION (cont'd)

### WARNINGS AND PRECAUTIONS (cont'd)

#### • Retinal Vasculitis and/or Retinal Vascular Occlusion

- Retinal vasculitis and/or retinal vascular occlusion, typically in the presence of intraocular inflammation, have been reported with the use of SYFOVRE. Cases may occur with the first dose of SYFOVRE and may result in severe vision loss. Discontinue treatment with SYFOVRE in patients who develop these events. Patients should be instructed to report any change in vision without delay.

# Step 1 (cont'd): Get to know the ApellisAssist program

ApellisAssist is a program designed to help your patients along their treatment journey



The ApellisAssist program provides your patients with a support system throughout their SYFOVRE treatment inclusive of:



Insurance support for SYFOVRE



ECP online portal



Financial assistance for eligible patients



Ongoing support via a dedicated Apellis Care Educator (ACE)

We recognize that you are the expert in your patients' care. The ApellisAssist program is here to provide support by helping patients overcome potential access barriers to treatment.

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Website: **SyfovreECP.com**

Portal: **ApellisAssistGA.com**  
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## IMPORTANT SAFETY INFORMATION (cont'd)

### WARNINGS AND PRECAUTIONS (cont'd)

#### • Neovascular AMD

- In clinical trials, use of SYFOVRE was associated with increased rates of neovascular (wet) AMD or choroidal neovascularization (12% when administered monthly, 7% when administered every other month and 3% in the control group) by Month 24. Patients receiving SYFOVRE should be monitored for signs of neovascular AMD. In case anti-Vascular Endothelial Growth Factor (anti-VEGF) is required, it should be given separately from SYFOVRE administration.



Please see additional Important Safety Information throughout and the full [Prescribing Information](#).

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# Step 2: Enroll your patient in the ApellisAssist program

Once you decide SYFOVRE is right for your GA patient, enroll them in ApellisAssist support services in 1 of 2 ways<sup>a</sup>

Register for the portal and submit your request online at **ApellisAssistGA.com**

OR

Download the Enrollment Form at **SyfovreECP.com** and fax the completed form to **888-405-6966**

To successfully complete the Enrollment Form, please make sure:

## 1 All information is complete and accurate

**ENROLLMENT FORM** Phone: 888-APELLIS (888-273-5547) • Fax: 888-405-6966

**SYFOVRE**  
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**\*Required Field**

**\*Section 1. Support Request**  
Check here for all available services (Checking "all" allows for support services throughout the patient journey, but only when needed)  
OR choose individual services below:  
 Benefits Investigation Only  Prior Authorization Assistance  Co-pay Program (commercially insured patients)  Patient Assistance Program (uninsured or underinsured patients)

**Section 2. Patient Information**  
\*First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ \*Last Name: \_\_\_\_\_  
Gender:  Male  Female  Other: \_\_\_\_\_ \*Date of Birth (MM/DD/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_  
\*Preferred Phone: \_\_\_\_\_  Home Phone  Mobile Phone Email: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
Preferred Language:  English  Spanish  Other: \_\_\_\_\_

**Section 3. Caregiver Information (optional)**  
Does patient have a caregiver with whom they would like ApellisAssist to share information?  Yes  No (If yes, please complete this section)  
Caregiver First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Preferred Phone: \_\_\_\_\_  Home Phone  Mobile Phone Email: \_\_\_\_\_  
What is the caregiver's relationship to the patient?  Legal Guardian  Spouse  Sibling  Other: \_\_\_\_\_

**Section 4. Patient Insurance**  
\*Does patient have insurance?  Yes  No

**Primary Insurance** (If copy of card is attached, check here)  
\*Payer Name and Payer ID: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Policyholder Name: \_\_\_\_\_  
Policyholder DOB: \_\_\_\_\_  
\*Policy Number: \_\_\_\_\_  
Employer/Group Number: \_\_\_\_\_

**Secondary Insurance** (If copy of card is attached, check here)  
\*Payer Name and Payer ID: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Policyholder Name: \_\_\_\_\_  
Policyholder DOB: \_\_\_\_\_  
\*Policy Number: \_\_\_\_\_  
Employer/Group Number: \_\_\_\_\_

(Optional Section) Pharmacy (PBM) Name: \_\_\_\_\_  
PBM Group ID: \_\_\_\_\_ PBM BIN/PCN: \_\_\_\_\_ PBM Phone Number: \_\_\_\_\_

**Section 4.1 Financial Information** (Must be completed for Patient Assistance Program requests only)  
How many people live in the patient's household? \_\_\_\_\_  
Total annual household income (including salary/wages; Social Security income; disability income; any other income):  
 Less than \$150,000  Greater than \$150,000  
Supporting documentation may be required. ApellisAssist may also ask for proof of income at any time for audit/verification.

**\*Section 5. Patient Authorization** This form cannot be processed without the patient's signature.  
 I have read and agree to Section 10.1 Authorization to Share Personal Health Information (required)  I have read and agree to Section 10.2 Authorization to Enroll in ApellisAssist Patient Support Program (required)  I have read and agree to Section 10.3 Authorization to Receive Marketing Communications (optional)

○ Patient Signature \_\_\_\_\_ Date (MM/DD/YYYY) \_\_\_\_\_

Please see Indication and Important Safety Information on page 6 and the full Prescribing Information. Page 1 of 6

## 2 Prescriber signs the form

### \*Section 9. Physician Declaration and Authorization

This form allows Apellis Pharmaceuticals, Inc., its affiliates, representatives, agents, partners, vendors and contractors ("Apellis") to provide patient support, resources and education ("Patient Resources") to eligible patients who have been prescribed SYFOVRE. I have the necessary written authorization from the patient referenced above, or the patient's legal guardian, to release to Apellis the medical and/or other patient information included herein for allowing participation in programs and services offered through ApellisAssist, which may include, without limitation: (i) financial assistance programs; (ii) verifying insurance coverage and/or evaluating the patient's eligibility for alternate funding; and (iii) Patient Resources. I certify that: (i) the information in this form is complete and accurate to the best of my knowledge; (ii) the patient on this form has a diagnosis for an FDA-approved indication for SYFOVRE; (iii) any Patient Resource provided through Apellis to my patient is not made in exchange for any express or implied agreement or understanding that I would recommend, prescribe, or use an Apellis medication or Patient Resource; (iv) SYFOVRE is prescribed solely on my clinical determination and medical necessity, and no claim for reimbursement will be submitted to Medicare, Medicaid, or any third-party payer for medication received free of charge, or for related medical procedures and services; nor will the free product be sold, traded, or distributed for sale; I will notify Apellis immediately if SYFOVRE is no longer medically necessary for this patient or if my patient's insurance status changes; (iv) I authorize Apellis to forward the above prescription to the applicable pharmacy as allowed under applicable law.

The SYFOVRE Co-Pay Program is for eligible patients enrolled in the ApellisAssist® program, are commercially insured, and are not covered under government insurance programs such as Medicare, Medicaid, VA/DoD, or TRICARE. The program assists only with the cost of SYFOVRE and its administration (injection) up to the program maximum. It does not assist with the cost of other administrations, medicines, procedures or office visits. Eligible patients residing in Massachusetts or Rhode Island can only receive assistance with the cost of SYFOVRE but not the cost of its administration. Patients receiving assistance through another program or foundation, free trial, or other similar offer or program, are not eligible for the program. Apellis reserves the right to modify or terminate the program at any time without notice.

○ Physician Signature (Dispense As Written) OR Physician Signature (If Drug Substitution Allowed) Date (MM/DD/YYYY)  
This form cannot be processed without the physician's signature (no stamp).

## 3 Patient consent is obtained

### \*Section 5. Patient Authorization

 This form cannot be processed without the patient's signature.

I have read and agree to Section 10.1 Authorization to Share Personal Health Information (required)  I have read and agree to Section 10.2 Authorization to Enroll in ApellisAssist Patient Support Program (required)  I have read and agree to Section 10.3 Authorization to Receive Marketing Communications (optional)

○ Patient Signature \_\_\_\_\_ Date (MM/DD/YYYY) \_\_\_\_\_

To obtain electronic consent, direct your patient to <https://hipaconsent.com/>

## What happens next?

The ApellisAssist program will provide your office with a status update on your patient's enrollment within 1 business day. The ApellisAssist team will check the patient's insurance coverage for SYFOVRE, identify any initial coverage requirements, and assess eligibility for financial assistance.

<sup>a</sup>Any patient enrollment submitted to ApellisAssist may be viewed in the ApellisAssist portal no matter how the enrollment was submitted (portal, tablet-based technology, or fax). Providers must establish an account within the ApellisAssist portal to view patient enrollment statuses and to submit enrollments via the ApellisAssist portal.

## IMPORTANT SAFETY INFORMATION (cont'd)

### WARNINGS AND PRECAUTIONS (cont'd)

#### • Intraocular Inflammation

- In clinical trials, use of SYFOVRE was associated with episodes of intraocular inflammation including: vitritis, vitreal cells, iridocyclitis, uveitis, anterior chamber cells, iritis, and anterior chamber flare. After inflammation resolves, patients may resume treatment with SYFOVRE.



Please see additional Important Safety Information throughout and the full Prescribing Information.


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# Step 3: Review insurance coverage information

## Review the Summary of Benefits provided by the ApellisAssist program to determine insurance requirements

If your office requested that ApellisAssist complete the patient's benefits investigation, then you will receive a Summary of Benefits within 1 business day (upon receipt of the completed enrollment form).

**Benefit Verification Summary for SYFOVRE® (pegcetacoplan injection)**



Patient Name:		DOB:
Patient HUB ID:		
<b>Primary Medical Insurance:</b>		
Insurance Phone Number:		
Payer Type:		Plan Type:
ID#:	Group#:	Effective Date:
<b>Secondary Medical Insurance:</b>		
Insurance Phone Number:		
Payer Type:		Plan Type:
ID#:	Group#:	Effective Date:
SYFOVRE Billing Code:		Administration CPT Code:
NDC:		
<b>Primary Insurance</b>		
Is SYFOVRE Covered: <input type="checkbox"/> Yes <input type="checkbox"/> No		Network Benefits: <input type="checkbox"/> In network <input type="checkbox"/> Out of Network
Individual Deductible: Amount Met:		Buy and Bill: <input type="checkbox"/> Specialty Pharmacy: <input type="checkbox"/> Required: <input type="checkbox"/> Optional: <input type="checkbox"/>
Drug Copay/ Co-Insurance:	Office Visit Copay/ Co-Insurance:	Admin Copay/ Co-Insurance:
Prior Authorization Required: <input type="checkbox"/> Yes <input type="checkbox"/> No		Prior Authorization Submission:
Prior Authorization Submission Details:		Online: Electronic: Fax: Phone:
<b>Secondary Insurance</b>		
Is SYFOVRE Covered: <input type="checkbox"/> Yes <input type="checkbox"/> No		Network Benefits: <input type="checkbox"/> In network <input type="checkbox"/> Out of Network
Individual Deductible: Amount Met:		Buy and Bill: <input type="checkbox"/> Specialty Pharmacy: <input type="checkbox"/> Required: <input type="checkbox"/> Optional: <input type="checkbox"/>
Drug Copay/ Co-Insurance:	Office Visit Copay/ Co-Insurance:	Admin Copay/ Co-Insurance:
Prior Authorization Required: <input type="checkbox"/> Yes <input type="checkbox"/> No		Prior Authorization Submission:
Prior Authorization Submission Details:		Online: Electronic: Fax: Phone:

Verification of benefits or coverage is not a guarantee of eligibility or coverage. Benefits reported in this Benefits Investigation reflect information provided by the patient's insurer as of the date reflected herein. All benefits and payments are subject to the patient's beneficiary eligibility at the time provider services are rendered. Actual payment of the claim is based on the terms and conditions of the patient's beneficiary plan. All claims are subject to review by the insurance provider upon submission of a claim by you to the insurance provider. All benefits quoted reflect "in-network" benefits unless otherwise noted.

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### A Summary of Benefits includes:

- Coverage details
- PA requirements (if applicable)
- Patient out-of-pocket costs

The practice should review the Summary of Benefits to determine if a PA is required or if the patient may need financial assistance from Apellis.

## IMPORTANT SAFETY INFORMATION (cont'd)

### WARNINGS AND PRECAUTIONS (cont'd)

- **Increased Intraocular Pressure**
  - Acute increase in IOP may occur within minutes of any intravitreal injection, including with SYFOVRE. Perfusion of the optic nerve head should be monitored following the injection and managed as needed.



Please see additional Important Safety Information throughout and the full Prescribing Information.



# Step 4: Obtain prior authorization (if required)

## The ApellisAssist program and your FRM can help guide you through the PA process

Payers may require a PA describing your patient's medical history and the reasons why SYFOVRE has been prescribed. Various health plans have different requirements. It is important to check with your patient's health plan to ensure you are using the correct form and supplying all the required information. To avoid delays, it is prudent to include a **Letter of Medical Necessity** to support the PA submission.

### PA checklist

#### Helpful reminders for the PA process

- ✓ Confirm PA requirements and how the PA should be submitted (eg, fax, phone, or online)
- ✓ Determine if the health plan has a specific form that must be used and if it is available online
- ✓ Check the health plan's policy for treating GA with SYFOVRE to ensure medical documentation addresses specific policy requirements
- ✓ Use the appropriate billing codes



The **Billing and Coding Guide** can be downloaded at [SyfovreECP.com](https://www.syfovre.com/SyfovreECP.com)

**All PA forms must be filled out and submitted by a patient's healthcare provider based on their clinical judgment and assessment of the patient's case.**

#### Letter of Medical Necessity *(some payers may require this)*

- ✓ Be specific in your request (ie, requesting approval of the PA to support the prescribed medication)
- ✓ Highlight the clinical assessments that demonstrate the patient need and that the patient meets the health plan medical policy criteria for treatment with SYFOVRE
- ✓ Include a copy of the health plan medical policy, if available
- ✓ Include the physician's contact information



A sample LMN can be downloaded at [SyfovreECP.com](https://www.syfovre.com/SyfovreECP.com)

## IMPORTANT SAFETY INFORMATION (cont'd)

### ADVERSE REACTIONS

- Most common adverse reactions (incidence  $\geq 5\%$ ) are ocular discomfort, neovascular age-related macular degeneration, vitreous floaters, conjunctival hemorrhage.



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# Step 4 (cont'd): Obtain prior authorization (if required)

## Follow up!

- ✓ Call to make sure the PA request was received
- ✓ Keep a record of your phone calls: who you talked to, when, and what was agreed to or discussed
- ✓ Document the PA approval number and duration (with written confirmation, if possible)
- ✓ Include the PA reference number on the claim form, if possible

## What happens next?

- 1** If the PA is approved, be sure to document the PA approval number/date in the patient's record and make note of the expiration date
- 2** If the PA is denied, you can file an appeal. The ApellisAssist program can support you and provide information about how your office can properly file this paperwork. The following PA denial appeal checklist may be helpful as you're preparing an appeal:
  - ✓ Review the denial letter to understand the reason for the denial and note any deadlines for next steps
  - ✓ Compile supporting medical information, documentation, and clinical assessments
  - ✓ Submit the first appeal per the health plan's process and requirements
  - ✓ If rejected, submit a second appeal that responds to the health plan's concerns, questions, or requirements
  - ✓ Many health plans' appeal policies allow up to 2 levels of internal appeal for PA denials. You may have the right to request an external appeal, which can include a review by an independent expert not affiliated with the health plan or an external review board. Be sure to note any deadlines for these additional appeals

## IMPORTANT SAFETY INFORMATION

### CONTRAINDICATIONS

- SYFOVRE is contraindicated in patients with ocular or periocular infections, and in patients with active intraocular inflammation



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## Step 5: Understand patient financial assistance eligibility

Financial assistance options are available for SYFOVRE patients who are enrolled in the ApellisAssist program and meet eligibility requirements.

ApellisAssist will notify your office and patient of financial assistance eligibility.

### Financial Assistance Programs include:



#### Patient Assistance Program<sup>a</sup>

A program for patients who are uninsured (no insurance), underinsured (limited or no pharmacy/medical benefit), or functionally uninsured (denied coverage by their insurance)



#### Co-pay Assistance<sup>b,c</sup>

A program for commercially insured patients that assists with co-pay and co-insurance expenses

<sup>a</sup>Program eligibility criteria, including annual household income limits, apply.

<sup>b</sup>The SYFOVRE Co-pay Program is for eligible patients who are enrolled in the ApellisAssist program, are commercially insured, and are not covered under government insurance programs such as Medicare, Medicaid, VA/DoD, or TRICARE. Apellis reserves the right to modify or terminate the program at any time without notice.

<sup>c</sup>The program assists only with the cost of SYFOVRE and its administration (injection) up to the program maximum. It does not assist with the cost of other administrations, medicines, procedures, or office visits. Eligible patients residing in Massachusetts or Rhode Island can only receive assistance with the cost of SYFOVRE but not the cost of its administration. Patients receiving assistance through another program or foundation, free trial, or other similar offer or program, are not eligible for the program.

## Step 6: Confirm product acquisition method



SYFOVRE is typically acquired via buy and bill, which means your office buys product from your specialty distributor, administers the product, and then bills the payer.

Alternatively, in some cases, SYFOVRE may be acquired via a specialty pharmacy.



More information on distributors and methods of acquisition can be found in the SYFOVRE **Product Ordering Guide** located at [SyfovreECP.com](https://www.syfovre.com/SyfovreECP.com)

### IMPORTANT SAFETY INFORMATION (cont'd)

#### WARNINGS AND PRECAUTIONS

##### • Endophthalmitis and Retinal Detachments

- Intravitreal injections, including those with SYFOVRE, may be associated with endophthalmitis and retinal detachments. Proper aseptic injection technique must always be used when administering SYFOVRE to minimize the risk of endophthalmitis. Patients should be instructed to report any symptoms suggestive of endophthalmitis or retinal detachment without delay and should be managed appropriately.



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## Step 7: Submit the claim

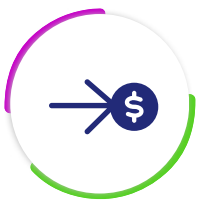


Billing information, including codes and tips on completing forms accurately and completely, is available in the SYFOVRE **Billing and Coding Guide** located at [Syfovrecp.com](https://www.syfovrecp.com)

Note that coding information provided in the **Billing and Coding Guide** is for informational purposes only and is subject to change.

- Codes may not apply to all patients or all payers. Providers should use their own independent and clinical judgment when selecting coding information
- Practices should contact the patient's health plan for specific information on coverage, coding, and reimbursement policies

## Step 8: Understand and manage reimbursement



It is important to understand the processes related to reimbursement for your practice. To do this, you can:

- Determine the reimbursement rate based on the plan contract and published fee schedules
- Establish a reconciliation process to ensure all inventory is captured in the billing process
- Track claims to ensure appropriate payment is received

### IMPORTANT SAFETY INFORMATION (cont'd)

#### WARNINGS AND PRECAUTIONS (cont'd)

##### • Retinal Vasculitis and/or Retinal Vascular Occlusion

- Retinal vasculitis and/or retinal vascular occlusion, typically in the presence of intraocular inflammation, have been reported with the use of SYFOVRE. Cases may occur with the first dose of SYFOVRE and may result in severe vision loss. Discontinue treatment with SYFOVRE in patients who develop these events. Patients should be instructed to report any change in vision without delay.

## Step 9: Appeal denied claims

### The ApellisAssist program and your FRM can help guide you through the appeals process

If the claim is denied, follow the appeals process, which may involve a series of steps. Various health plans have different processes, and it is important to check with your patient's plan to confirm their requirements.

#### Appeal checklist

- ✓ Review the denial letter to understand the reason for the denial and note any deadlines for next steps
- ✓ Compile supporting medical information, documentation, and clinical assessments
- ✓ Submit the first appeal per the health plan's process and requirements
- ✓ If rejected, submit a second appeal that responds to the health plan's concerns, questions, or requirements
- ✓ Many health plans' appeal policies allow up to 2 levels of internal appeal for claim denials. You may have the right to request an external appeal, which can include a review by an independent expert not affiliated with the health plan or an external review board. Note any deadlines for these additional appeals

**All forms must be filled out and submitted by a patient's healthcare provider based on their clinical judgment and assessment of the patient's case.**



A sample Appeals Letter can be downloaded at [SyfovreECP.com](https://www.syfovre.com/SyfovreECP.com)

## Step 10: Prepare for PA reauthorization (if applicable)

### The ApellisAssist program is available to help determine payer reauthorization requirements and criteria

- Depending on your patient's health plan medical policy, reauthorization for SYFOVRE may be required after 6–12 months of treatment. ApellisAssist is available to help determine payer reauthorization requirements and criteria (eg, upon PA expiration or yearly), which may be subject to change without notice
- Consider making a note in your patient's medical record to initiate the reauthorization process early enough to maintain continuity of treatment



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## INDICATION

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### WARNINGS AND PRECAUTIONS

#### • Endophthalmitis and Retinal Detachments

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#### • Retinal Vasculitis and/or Retinal Vascular Occlusion

- Retinal vasculitis and/or retinal vascular occlusion, typically in the presence of intraocular inflammation, have been reported with the use of SYFOVRE. Cases may occur with the first dose of SYFOVRE and may result in severe vision loss. Discontinue treatment with SYFOVRE in patients who develop these events. Patients should be instructed to report any change in vision without delay.

#### • Neovascular AMD

- In clinical trials, use of SYFOVRE was associated with increased rates of neovascular (wet) AMD or choroidal neovascularization (12% when administered monthly, 7% when administered every other month and 3% in the control group) by Month 24. Patients receiving SYFOVRE should be monitored for signs of neovascular AMD. In case anti-Vascular Endothelial Growth Factor (anti-VEGF) is required, it should be given separately from SYFOVRE administration.

#### • Intraocular Inflammation

- In clinical trials, use of SYFOVRE was associated with episodes of intraocular inflammation including: vitritis, vitreal cells, iridocyclitis, uveitis, anterior chamber cells, iritis, and anterior chamber flare. After inflammation resolves, patients may resume treatment with SYFOVRE.

#### • Increased Intraocular Pressure

- Acute increase in IOP may occur within minutes of any intravitreal injection, including with SYFOVRE. Perfusion of the optic nerve head should be monitored following the injection and managed as needed.

### ADVERSE REACTIONS

- Most common adverse reactions (incidence  $\geq 5\%$ ) are ocular discomfort, neovascular age-related macular degeneration, vitreous floaters, conjunctival hemorrhage.

Please see full [Prescribing Information](#) for more information.



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