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BENEFITS INVESTIGATION

This resource is provided for informational purposes only. It is always the provider's responsibility to determine details specific to individual patients and to submit true and correct claims for the products and services rendered. Providers should contact third-party payers for specific information on their coding, coverage, payment policies, and fee schedules. Geron and its agents make no guarantee regarding reimbursement for any service or item. **This resource is not intended as reimbursement advice, legal advice, medical advice, or a substitute for a provider's independent professional judgment.**

The Importance of a Thorough and Complete Benefits Investigation

A benefits investigation is a crucial first step for determining a patient's coverage, helping to facilitate a patient's timely start to treatment. Completing a benefits investigation will help to identify the insurance plan's coverage details and coding requirements. For each patient, your office will need to determine how the patient's insurance plan covers the medication and the applicable IV administration CPT® codes.

Insurance plan coverage varies and can change over time, so it is important to determine the patient's coverage before each infusion. This is especially important if a medication is being administered at a different site of care for the first infusion.

An Overview of the Benefits Investigation Process

Gather Patient and Provider Information

Contact Insurance Plan to Verify Benefits

Document Benefits in the Patient's Records

REACH4RYTELO™

REACH4RYTELO can support the benefits investigation process for enrolled patients. Call REACH4RYTELO at **1-844-4RYTELO (1-844-479-8356)**, Monday through Friday, from 8:00 AM to 8:00 PM ET.[a]

It is the responsibility of the prescriber's office to confirm the patient's coverage.

[a]All programs provided through REACH4RYTELO are subject to eligibility requirements. Geron reserves the right to modify or discontinue REACH4RYTELO at any time without notice.

CPT®=Current Procedural Terminology; IV=intravenous.

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Part 1: Gather Patient, Provider, and Coding Information

To support a thorough benefits investigation, all patient, provider, coding, and site of care information should be readily available prior to contacting the insurance plan.

Patient Information

Contact Information	Primary Insurance Information	Additional Insurance Information
• Name • Date of birth • Phone number	• Policyholder name • Policy start and end dates • Group number • Member number	• Secondary and tertiary insurance plan information if applicable (eg, Medicare supplements)

Provider Information

Prescriber	Administering Provider(s) (if different from the prescriber)	Site of Care for Administration
• Name • NPI number • Tax ID number	• Name(s) • NPI number(s) • Tax ID number(s)	• Practice or facility name • NPI number • Administration site

Please see the **Billing and Coding Guide** to reference NDC codes for RYTELO and commonly used HCPCS and CPT codes.

NOTE

For frequently asked questions about **who pays first when coordinating benefits for Medicare beneficiaries**, refer to the **Medicare.gov** website.

HCPCS=Healthcare Common Procedure Coding System; ID=identification; NDC=National Drug Code; NPI=National Provider Identifier.

Part 2: Contact Insurance Plan to Verify Benefits

Consider following the 8-step process below to obtain comprehensive benefits information from your patient's insurance plan(s). Take notes during the conversation with the insurance plan for the patient's records.

Example Benefits Verification Process

STEP 1
Call the provider services phone number on the back of the patient's medical insurance card. Ask if RYTELO is covered under the medical benefit and request a copy of the published RYTELO policy if one is available. Determine which coverage and criteria apply to your patient.

STEP 2
Ask if a prior authorization or other type of review is required and what the submission process is. Ask about the ability to request an urgent or expedited review. Establish whether specific documentation is required for the submission. Inquire about the reauthorization interval.

STEP 3
Confirm whether the provider and the administration site is in network. Ask about specific payer requirements regarding site of care and product administration coverage.

STEP 4
Determine if there are any payer-specific dispensing requirements for RYTELO, including whether there are requirements related to ordering through specialty distributors (SDs) or specialty pharmacies (SPs). See the **Product Ordering Guide** for a list of Geron's authorized SDs and SPs.

STEP 5
Confirm the patient's policy effective date, annual deductible, out-of-pocket maximum, and how much has been met to date. Determine if the patient will be responsible for coinsurance or copay for RYTELO and any administration-related services for RYTELO.

STEP 6
Prepare for future billing by confirming any payer-specific billing requirements for RYTELO.

STEP 7
Inquire about the reimbursement process. Determine if the facility or professional services are subject to global payment rules or prospectively set reimbursement rates.

STEP 8
Verify coordination of benefits (who pays in what order).

NOTE

If the patient has multiple insurance plans, **repeat the 8-step process for each plan**.

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Consider Documenting Benefits in the Patient's Records

You may be communicating with your patient's insurance plan(s) several times during the benefits investigation.

Consider documenting each communication exchange your office has with your patient's insurance plan(s) and ensuring that notes are appropriately recorded in the patient's medical records.

- ☐ Date of communication
- ☐ Time of communication
- ☐ Person(s) you spoke with
- ☐ Contact information (direct phone line, email)
- ☐ Communication preference (fax, email)
- ☐ Reference number for call
- ☐ Summary of communication

Notes from the benefits investigation can be referred to throughout the billing and reimbursement process.

REACH4RYTELO™

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