RUCONEST SOLUTIONS™
Expertise. Delivered personally.

RUCONEST Solutions™ Reimbursement Form

Instructions for this form:
Please complete this form and return to RUCONEST Solutions™ in one of the following ways:

- **Via fax to 1-855-423-5757**
- **Via email to RUCONESTSOLUTIONS@lashgroup.com**
- **Via mail to**

  RUCONEST SOLUTIONS
  PO BOX 221974
  CHARLOTTE, NC 28222

This form can be found online at https://www.ruconest.com/resources

This RUCONEST Solutions™ Reimbursement Form is to be used to seek reimbursement for out-of-pocket medical and travel expenses pertaining to RUCONEST® (C1 esterase inhibitor [recombinant]) infusion or education. Examples of acceptable ancillary RUCONEST expenses include pharmacy supplies, ambulance rides, long-distance travel to a hereditary angioedema specialist, and attendance or travel for advocacy events. You must submit this form with a detailed description that ties the charge(s) back to a RUCONEST-related event, supply, or service and proof of payment in the form of a receipt or an explanation of benefits (EOB) showing the remaining patient balance. Maintain a copy of all documentation for your records.

Personal Information

Last Name..... First Name..... M.I.....
Street/P.O. Box/Apt Number.....
City..... State..... Zip Code.....
Email Address..... Telephone number.....

MEDICAL/EDUCATIONAL EXPENSE REIMBURSEMENT

For each line item, give the name of the doctor's office, hospital, pharmacy, medical supply company, or educational entity where the expense was incurred. List the description of charges. For prescriptions, you must include the National Drug Code (NDC) number, quantity (how many mL/mg), and the days of supply. Enter the date of service range and amount paid out of pocket. If the expense occurred on one day, enter the same date in the From and To columns. Write "YES" to state that you have included proof of payment. Up to 8 visits and/or services can be listed on this form. Calculate the total amount paid for all visits and fill in the box at the bottom.

Name of doctor's office, hospital, pharmacy, medical supply company, or educational entity where expense was incurred	Description of charge (medical appointment, name of prescription drug, description of medical product/ supply)	Date of service (MM/DD/YYYY)		Amount paid by claimant	Have you included proof of payment for each item?
		From	To		YES/NO
		TOTAL REIMBURSEMENT			

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Travel Reimbursement

Date of travel...../...../..... ☐ One-way ☐ Round Trip

Travel from:

☐ Hospital
☐ Office/clinic
☐ Lab
☐ Advocacy/educational event
☐ Home
☐ Other:

.....

Travel to:

☐ Hospital
☐ Office/clinic
☐ Lab
☐ Advocacy/educational event
☐ Home
☐ Other:

.....

Medical facility or advocacy event name and address (must be listed whether you were going to or leaving the facility/event):

.....

Total expense/cost

Add an X next to each type of expense	Type	Description	Amount
	Taxi/rideshare		
	Bus/train		
	Tolls/parking		
	Lodging		
	Meals		
	Other (specify)		
		TOTAL REIMBURSEMENT	

Private auto only miles traveled: .....

Note: Claimants are reimbursed per mile and not based on a gas receipt. Miles should include only whole numbers.

I certify that the information above is correct and that the reimbursement requested is for expenses paid by me for treatment or services associated with RUCONEST infusion or education. I am aware that any person who knowingly makes any false statement or misrepresentation to obtain reimbursement from RUCONEST Solutions™ is subject to civil penalties and/or criminal prosecution.

Patient Sign

Patient signature required: ..... Date .....

Attention! Proof of payment in the form of a receipt or an EOB showing the remaining patient balance is required for each expense listed on this form. Scan or attach copies to this form and include them with your submission via fax, email, or mail as listed on the top of page 1 of this form.

This program is restricted to patients with commercial insurance for the treatment of hereditary angioedema. *The Program only applies in the United States, including Puerto Rico and other US territories, and does not apply where prohibited by state law or other restrictions. As a reminder, you are responsible for notifying* ***RUCONEST SOLUTIONS™*** *in the event of any changes that may impact your eligibility, such as becoming eligible for any form of Medicare, Medicaid, Tricare, or veterans' health insurance. Program is subject to availability, and Pharming Healthcare Inc. reserves the right to rescind, revoke, or amend the Program at any time without notice.*