2010 SHARING HOPE PROGRAM FOR WOMEN

Criteria and Application

LIVESTRONG®

Made possible by participating reproductive endocrinologists and EMD Serono, Inc.

The Sharing Hope program for women was inspired by the experiences of Lindsay Nohr Beck, Fertile Hope's Founder & Executive Director, at Stanford Medical Center.

PROGRAM OVERVIEW

Goal

Cancer patients have little opportunity to save for the high costs of cancer treatment, let alone budget for procedures or treatments intended to preserve the possibility of conceiving with their own eggs. Yet there is only a small window of opportunity between diagnosis and treatment during which cancer patients may pursue these options, and the upfront costs are often prohibitive. The goal of the LIVE**STRONG** Sharing Hope program for women is to increase access to such procedures and treatments for qualified women diagnosed with cancer in their reproductive years.

The LIVE**STRONG** Sharing Hope program, formerly administered by Fertile Hope, is proud to offer assistance to qualified female applicants by providing access to fertility medications donated by EMD Serono, Inc., and discounted services from reproductive endocrinologists from across the country.

Overview

The Sharing Hope program does not grant direct financial contributions to individuals, but instead has partnered with key organizations to increase access to procedures and treatments intended to preserve the possibility of fertility for certain qualified cancer patients whose medical treatments present the risk of infertility and who meet the criteria set forth below.

For a list of participating facilities, visit LIVE**STRONG**.org/fertilehope or call 866.965.7205.

What is covered?

LIVE**STRONG**'s Sharing Hope program for women helps reduce the cost of embryo freezing and egg freezing procedures.

Embryo freezing is a medically accepted way to preserve the possibility of fertility. First, the ovaries are stimulated to mature multiple eggs. Doctors remove the mature eggs and fertilize them in the lab with sperm from a partner or donor to create embryos. The fertilization process is called in vitro fertilization (IVF). Embryos are then frozen for future use. The steps involved in embryo freezing require between two and six weeks.

Egg freezing may be an option for women who do not have a male partner and do not want to use donor sperm. First, the ovaries are stimulated to mature multiple eggs. Doctors then remove the mature eggs and freeze them for future use. This procedure is considered experimental, which means it should only be offered in accordance with good clinical practice, including, but not limited to, any applicable guidelines issued by the American Society for Reproductive Medicine (ASRM) or similar professional organizations. The steps involved in egg freezing require between two and six weeks.

It is difficult to define the pregnancy rates associated with embryo and egg freezing for cancer patients because available data for this population is limited. For infertility patients, the literature suggests that pregnancy rates using frozen embryos are around 25 percent. According to a small number of studies with small study populations, pregnancy rates using frozen eggs can range anywhere from 20–35 percent, but these rates are not definitive. Pregnancy rates may increase with egg freezing when it is combined with ICSI (intracytoplasmic sperm injection), a procedure in which a single sperm is injected directly into an egg.

Certain medications prescribed by a reproductive endocrinologist to assist in the development of multiple follicles through ovarian stimulation will be provided through a donation from EMD Serono, Inc. to qualifying applicants (see eligibility criteria). Additionally, partnering local reproductive endocrinologists will offer embryo and egg freezing services at a significantly discounted rate. The program includes one embryo freezing or egg freezing procedure and certain medications prescribed by physicians for ovarian stimulation.

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Contact: LIVE**STRONG**; Attn: Sharing Hope; 2201 East Sixth Street; Austin, TX 78702; Fax: 212.504.7966

What is not covered?
While we understand the importance of other fertility preservation and parenthood options, LIVE**STRONG**'s Sharing Hope program for women only covers egg and/or embryo freezing. The reduced cost offered by the reproductive center does not include many of the ancillary costs of preparing for, going through or storage after treatment.

These additional costs could include, but are not limited to:

- Laboratory work performed on your behalf
- Anesthesia costs
- Doctor's fees
- Short-term or long-term storage of frozen eggs or embryos
- Implantation procedures
- Prenatal care

The program participant or her insurance company will have to bear the costs of services provided by entities or individuals not affiliated with the program, including, but not limited to, the costs associated with the ancillary services noted above. It is important to know what those costs are and to plan accordingly.

If a physician determines that treatments or medications other than the services provided by the fertility center are necessary, the participant will be responsible for the cost of such treatments and medications.

Some of the procedures and treatments that are covered by the Sharing Hope program are only available in major metropolitan areas. LIVE**STRONG** will make its best effort to refer patients to the nearest participating center or reproductive endocrinologist, but the program does not cover the cost of travel.

The Sharing Hope program does not cover the cost of oncology services or any associated expenses incurred during cancer treatments. Keep in mind that neither LIVE**STRONG** nor EMD Serono are medical providers; all program participants acknowledge and agree that neither LIVE**STRONG** nor EMD Serono shall be liable for any aspect of their current and future treatment. All cancer patients should discuss the risks, side effects, time requirements and other aspects of all treatment options with their physicians before selecting the most appropriate course of care.

For more information about the Sharing Hope program or the LIVE**STRONG** Survivor*Care* program, which can help anyone affected by cancer, contact us at 866.965.7205.

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HOW TO APPLY

Eligibility Criteria
LIVE**STRONG** selects participants for the Sharing Hope program based on the following criteria. Only patients who meet ALL of the following criteria will be accepted.

- U.S. citizen or permanent resident
- Annual household income is less than or equal to $75,000 (single) or $100,000 (married)
- Diagnosis of certain types of cancer
- Oncologist has determined that the recommended cancer treatments present the risk of infertility
- Individual has not yet started fertility-damaging cancer treatments
- Oncologist and reproductive endocrinologist have both determined that the treatments and associated medications are medically appropriate
- Uninsured or denied insurance coverage for the treatments and procedures required for embryo freezing or egg freezing
- Individual has not previously participated in the Sharing Hope program

Contact us directly for further clarification regarding any of the eligibility requirements listed above.

Application Requirements
Complete the following forms with the help of your medical team and make a copy for your records. Print clearly and submit your completed application to LIVE**STRONG** via mail, fax or email to:

LIVE**STRONG**
Attn: Sharing Hope
2201 E. Sixth Street
Austin, TX 78702
Fax: 212.504.7966
Email: survivorcare@LIVE**STRONG**.org

Note your application will NOT be processed if you do not meet the elegibility criteria listed above or if any of the following information has not been received:

- Completed Patient Authorization and Consent Form
- Completed Oncologist Referral and Certification Form
- Completed Reproductive Endocrinologist Certification Form
- Copy of your 1040 Federal Tax Return Form from the most recent year
  If you did not file taxes, call the IRS at 800.829.1040 and request a Tax Return Transcript.

Next Steps
LIVE**STRONG** will notify applicants of approval or denial by phone, mail and/or email within one week of receipt of the required forms. If we have not contacted you within that time frame, contact us to verify receipt. All approved applicants will receive an approval letter outlining next steps.

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PATIENT AUTHORIZATION AND CONSENT FORM

COMPLETE ALL THE FIELDS IN THE FOLLOWING FORM AND KEEP A COPY FOR YOUR RECORDS. *INCOMPLETE APPLICATIONS WILL NOT BE PROCESSED.*

NOTE: YOU SHOULD DISCUSS THE RISKS, SIDE EFFECTS AND OTHER ASPECTS OF ALL TREATMENT OPTIONS WITH YOUR PHYSICIANS BEFORE SELECTING THE BEST COURSE OF TREATMENT FOR YOU. IF AT ANY TIME YOUR PHYSICIANS HAVE ADVISED YOU OR DO ADVISE YOU TO SEEK TREATMENT FOR CANCER IMMEDIATELY, IT IS THE POSITION OF LIVE**STRONG** THAT YOU SHOULD NOT DELAY YOUR TREATMENTS IN ORDER TO PARTICIPATE IN THIS PROGRAM.

PERSONAL INFORMATION

LAST NAME ______ FIRST ______ MIDDLE ______

STREET ADDDRESS ______ CITY ______ STATE ______ ZIP CODE ______

SOCIAL SECURITY ______ DATE OF BIRTH ______

CANCER TYPE ______

PRIMARY PHONE ______ SECONDARY PHONE ______ EMAIL ______

☐ I GIVE LIVE**STRONG** PERMISSION TO SPEAK WITH ANOTHER PARTY REGARDING MY SHARING HOPE APPLICATION (E.G., PARENT/GUARDIAN, SIGNIFICANT OTHER, FRIEND).

NAME ______ RELATION ______ PRIMARY PHONE ______

INSURANCE INFORMATION

COMPANY NAME ______ GROUP NUMBER ______ POLICY NUMBER ______

TELEPHONE NUMBER ______ ☐ UNINSURED

FINANCIAL INFORMATION

AVERAGE THREE-YEAR ANNUAL HOUSEHOLD INCOME

I CERTIFY THAT MY YEARLY INCOME OR THREE-YEAR INCOME AVERAGE IS

- ☐ EQUAL TO OR LESS THAN $75,000 (FOR SINGLE APPLICANTS)
- ☐ EQUAL TO OR LESS THAN $100,000 (FOR MARRIED APPLICANTS)

CONFIRM

- ☐ I HAVE SENT IN MY 1040 FEDERAL TAX RETURN FORM FROM THE MOST RECENT YEAR.

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Applicant Certification and Authorization to Release Medical Information

I certify that all of the information provided in this application is complete and accurate. I authorize the release of the information contained in this application. I understand it is for the sole use of LIVE**STRONG**, its program participants, its representatives and/or agents in order to assess my eligibility for participation in the Sharing Hope program. I authorize LIVE**STRONG**, its representatives and/or agents to request and obtain from my physicians and any insurer any medical or other patient information related to my treatment for cancer and infertility. I also authorize LIVE**STRONG**, its representatives and/or agents to share the information contained herein with EMD Serono, Inc. and participating fertility centers in order to secure assistance for me under the Sharing Hope program. I agree to immediately inform LIVE**STRONG** if my income or insurance status changes and to provide any documentation that LIVE**STRONG** requests to verify the same. I further authorize these parties to contact me directly, if necessary, to process this application. I understand that my application for assistance from the Sharing Hope program does not guarantee that assistance will be provided. I understand that eligibility for the Sharing Hope program is subject to approval under the criteria and requirements set forth herein and that LIVE**STRONG** reserves the right to change or terminate this program without prior notice. I agree to abide by this certification and authorization throughout my participation in the Sharing Hope program and to notify LIVE**STRONG** if aspects of my certification and authorization are no longer applicable.

I understand that neither LIVE**STRONG** nor EMD Serono, Inc. are medical providers, and by submitting this application with my signature below, I acknowledge and agree that neither LIVE**STRONG** nor EMD Serono, Inc. shall be liable for any aspect of my current and future treatment. I understand that there are no guarantees that the procedures intended to assist in preserving fertility or the associated medications that may be provided to me under the Sharing Hope program will be successful in preserving my fertility. I also understand the experimental nature and success rates of the procedures and I agree that neither LIVE**STRONG** nor EMD Serono, Inc. shall be liable for any treatment failure.

I assume all risk of and financial responsibility for any loss or injury related directly or indirectly to my participation in the program and agree to indemnify and hold LIVE**STRONG** and EMD Serono, Inc. harmless from and against any and all costs, claims, demands, charges, liabilities, obligations or fees incurred or suffered by me as a result of, or arising out of, my participation in the Sharing Hope program except for claims resulting wholly from the gross negligence of LIVE**STRONG** or EMD Serono, Inc.

I understand that if I qualify for the Sharing Hope program, I may receive certain medications from EMD Serono, Inc. that my physician may prescribe in connection with one embryo freezing procedure or one egg freezing procedure. I understand that if I receive such medications, EMD Serono, Inc. is under no obligation to provide me with additional medications.

I understand the potential risks and side effects of taking such medications, and I have discussed with my physician any questions I have related to the medications. I have also discussed with my physicians the risks, side effects and other aspects of all treatment options before selecting the best course of treatment for me.

By signing below, I certify that I have completely and accurately disclosed, and at all times will completely and accurately disclose, my medical history to all of my health care providers, including but not limited to any oncologist or reproductive endocrinologist.

I understand that the agreements under the Sharing Hope program shall be construed and interpreted in accordance with the laws of the State of Texas without regard to its conflicts of law provisions.

PATIENT SIGNATURE ______________________________ DATE __________

PARENT/GUARDIAN SIGNATURE (IF PATIENT UNDER AGE 18) ______________________________ DATE __________

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Contact: LIVE**STRONG**; Attn: Sharing Hope; 2201 East Sixth Street; Austin, TX 78702; Fax: 212.504.7966

ONCOLOGIST REFERAL & CERTIFICATION FORM

COMPLETE ALL THE FIELDS IN THE FOLLOWING FORM AND KEEP A COPY FOR YOUR RECORDS. *INCOMPLETE APPLICATIONS WILL NOT BE PROCESSED*.

NOTE: YOU SHOULD DISCUSS THE RISKS, SIDE EFFECTS AND OTHER ASPECTS OF ALL TREATMENT OPTIONS WITH YOUR PATIENT BEFORE RECOMMENDING THE BEST COURSE OF TREATMENT. IF AT ANY TIME YOU HAVE ADVISED OR DO ADVISE YOUR PATIENT TO SEEK TREATMENT FOR CANCER IMMEDIATELY, IT IS THE POSITION OF LIVE**STRONG** THAT THE PATIENT SHOULD NOT DELAY TREATMENTS IN ORDER TO PARTICIPATE IN THIS PROGRAM.

PATIENT INFORMATION

LAST NAME ____ FIRST ____ MIDDLE ____

STREET ADDRESS ____ CITY ____ STATE ____ ZIP CODE ____

PRIMARY PHONE ____ SECONDARY PHONE ____ EMAIL ____

DOB ____

PHYSICIAN INFORMATION

LAST NAME ____ FIRST ____ MIDDLE ____

TITLE ____ STATE LICENSE NUMBER ____ FULL NAME OF CLINIC OR HOSPITAL ____

STREET ADDRESS ____ CITY ____ STATE ____ ZIP CODE ____

PHONE ____ FAX ____ EMAIL ____

HOSPITAL OR CLINIC CONTACT NAME ____

PHONE ____ FAX ____ EMAIL ____

TREATMENT INFORMATION

CANCER TYPE: ____

TREATMENT PLAN (CHECK ALL THAT APPLY)

- ☐ SURGERY TO THE REPRODUCTIVE AREA, EXPLAIN: ____
- ☐ RADIATION TO THE BRAIN OR REPRODUCTIVE AREA, EXPLAIN: ____
- ☐ CHEMOTHERAPY, EXPLAIN: ____
- ☐ OTHER, EXPLAIN: ____

TREATMENT TIMELINE (SHOULD FALL AFTER COMPLETION OF FERTILITY TREATMENT)

ESTIMATED START DATE ____ ESTIMATED END DATE ____

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For the following two questions, check yes or no. ANSWERS ARE REQUIRED FOR BOTH QUESTIONS; INCOMPLETE ANSWERS WILL DELAY PROCESSING.

MY INTENDED TREATMENT PLAN PRESENTS A RISK THAT THE PATIENT MAY BECOME INFERTILE.

☐ YES ☐ NO

ARE THERE ANY KNOWN MEDICAL CONTRAINDICATIONS TO THE ABOVE-NAMED PATIENT UNDERGOING FERTILITY PRESERVATION TREATMENTS AND THE ASSOCIATED RISKS AND SIDE EFFECTS?

☐ YES ☐ NO

I have discussed with the patient the risks, side effects and other aspects of all her treatment options.

I certify that I have read the full physician prescribing information for each of the EMD Serono, Inc. products that may be prescribed by a reproductive endocrinologist under this program (Gonal-f®, Ovidrel® PreFilled Syringe, Cetrotide® 0.25mg and Luveris® 75 IU) and that: the use of such medications for the above-named patient is consistent with each product's labeling, and in my medical judgment there is no reason that the above-named patient should not be treated with any one or more of these medications.

Neither LIVE**STRONG** nor EMD Serono, Inc. is a medical provider, and I acknowledge and agree that neither LIVE**STRONG** nor EMD Serono, Inc. shall be liable for any aspect of the treatment of the patient I have referred to LIVE**STRONG** for participation in the LIVE**STRONG** Sharing Hope program.

ONCOLOGIST SIGNATURE ______________________ DATE __________

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REPRODUCTIVE ENDOCRINOLOGIST CERTIFICATION FORM

COMPLETE ALL THE FIELDS IN THE FOLLOWING FORM AND KEEP A COPY FOR YOUR RECORDS. *INCOMPLETE APPLICATIONS WILL NOT BE PROCESSED*.

NOTE: YOU SHOULD DISCUSS THE RISKS, SIDE EFFECTS AND OTHER ASPECTS OF ALL TREATMENT OPTIONS WITH YOUR PATIENT BEFORE RECOMMENDING THE BEST COURSE OF TREATMENT. IF AT ANY TIME YOU HAVE ADVISED OR DO ADVISE YOUR PATIENT TO SEEK TREATMENT FOR CANCER IMMEDIATELY, IT IS THE POSITION OF LIVE**STRONG** THAT THE PATIENT SHOULD NOT DELAY TREATMENTS IN ORDER TO PARTICIPATE IN THIS PROGRAM.

PATIENT INFORMATION

LAST NAME ______ FIRST ______ MIDDLE ______

STREET ADDRESS ______ CITY ______ STATE ______ ZIP CODE ______

PRIMARY PHONE ______ SECONDARY PHONE ______ EMAIL ______

DOB ______

CANCER TYPE ______

PHYSICIAN INFORMATION

LAST NAME ______ FIRST ______ MIDDLE ______

TITLE ______ STATE LICENSE NUMBER ______ FULL NAME OF CLINIC OR HOSPITAL ______

STREET ADDRESS ______ CITY ______ STATE ______ ZIP CODE ______

PHONE ______ FAX ______ EMAIL ______

HOSPITAL OR CLINIC CONTACT NAME ______

PHONE ______ FAX ______ EMAIL ______

TREATMENT PLAN

☐ Embryo Freezing ☐ Egg Freezing

INSURANCE COVERAGE

The patient listed above has been denied insurance coverage for the treatments and procedures required for the above-noted treatment plan.

SPECIFIC DRUG REQUESTED	AMT REQUIRED FOR PATIENT CYCLE	MAX QTY ALLOWED
(May choose only Pen OR Multi-Dose, not both)		
GONAL-F® 450 IU RFF PEN (FOLLITROPIN ALFA INJECTION)	______IU	3,150 IU (7 PENS)
GONAL-F® 450 IU MULTI-DOSE (FOLLITROPIN ALFA FOR INJECTION)	______IU	3,150 IU (7 VIALS)
CETROTIDE® 0.25 MG (CETRORELIX ACETATE FOR INJECTION)	______	5 BOXES OF 0.25 MG
OVIDREL® PREFILLED SYRINGE	______	1 SYRINGE
LUVERIS® 75 IU	______	10 (75 IU) VIALS

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Package inserts for EMD Serono Inc.'s US marketed products are available at emdserono.com or by calling 888.275.7376.

Neither LIVE**STRONG** nor EMD Serono, Inc. is a medical provider, and I acknowledge and agree that neither LIVE**STRONG** nor EMD Serono, Inc. shall be liable for any aspect of the treatment of the patient I have referred to LIVE**STRONG** for participation in LIVE**STRONG**'s Sharing Hope program. I certify that I have read the full physician prescribing information for each of the EMD Serono, Inc. products that may be prescribed by a reproductive endocrinologist under this program (Gonal-f®, Ovidrel® PreFilled Syringe, Cetrotide® 0.25mg and Luveris® 75 IU) and that: such medications are not contraindicated for the above-named patient, and in my medical judgment there is no reason that the above-named patient should not be treated with any one or more of these medications. I have discussed with the patient the risks, side effects and other aspects of all her treatment options. I have provided the patient with the patient information leaflet for each of the EMD Serono, Inc. medications available under the Sharing Hope program and discussed with her the potential risks and side effects of taking such medications.

I have also explained to her that there are no guarantees that the procedure or associated medications provided to her under the Sharing Hope program will be successful in her effort to conceive using her own eggs. I have discussed both the experimental nature and success rates of the procedures with the above-referenced patient and agree to undertake the procedure in accordance with good clinical practice, including but not limited to any applicable guidelines issued by the American Society for Reproductive Medicine or other similar professional organizations. I understand that any medications provided to me through the Sharing Hope program must be provided only to the above-named patient and are not for trade, sale or purchase. I agree that I will not seek reimbursement by any federal, state or private program for any of the medications provided to the above-named patient under the Sharing Hope program.

REPRODUCTIVE ENDOCRINOLOGIST SIGNATURE ______________________________ DATE ______________

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