azurity pharmaceuticals

**Directions:** For assistance, please complete this form and fax it to 1.866.927.2052.
You can also call 1.844.472.2032, Monday-Friday 8 AM–6 PM ET.

Myhibbin™ (mycophenolate mofetil oral suspension)

# PATIENT ASSISTANCE PROGRAM (PAP) - ENROLLMENT FORM (Patient MUST Be Uninsured)

REQUIRED FIELDS ARE MARKED IN **BOLD**. PLEASE NOTE THAT MISSING INFORMATION WILL DELAY OUR ABILITY TO ASSIST YOU IN ACCESSING THERAPY

## 1 PATIENT DEMOGRAPHIC INFORMATION

| | | | |
|---|---|---|---|
| **First Name:** | | **Last Name:** | |
| **DOB:** | Sex: | **Street Address:** | |
| **City:** | | **State:** | **ZIP Code:** |
| **Phone:** | | Consent to Contact? YES NO | |
| Contact for Legal Guardian (Complete if patient is <18 years old) | | First Name: | Last Name: |
| Relationship to Patient: | | Phone: | |

## 2 PATIENT FINANCIAL INFORMATION

| | |
|---|---|
| Annual Household Adjusted Gross Income: | Number of People Living in Household: |

## 3 PHYSICIAN INFORMATION

| | | | |
|---|---|---|---|
| **First Name:** | | **Last Name:** | Title: |
| **Facility Name:** | | **Street Address:** | |
| **City:** | **State:** | **ZIP Code:** | **Phone:** |
| **Fax:** | Contact Name: | Direct # or Extension: | |
| **Tax ID #:** | **NPI #:** | Email: | |

## 4 TREATMENT INFORMATION

| | |
|---|---|
| **Patient Diagnosis:** (List all that apply) | **ICD-10-CM Diagnosis Code(s):** (List all that apply) |

## 5 PRESCRIPTION (Complete this section only if the patient is applying to the patient assistance program)

Please indicate if the patient is currently prescribed **Myhibbin™ (mycophenolate mofetil oral suspension)** 200 mg/mL

YES NO

| | | | |
|---|---|---|---|
| **Myhibbin™ (mycophenolate mofetil oral suspension)** 200 mg/mL | Quantity: | Refills: | Patient Weight: |

**Special Instructions:**

## 6 PRESCRIBER CERTIFICATION AND SIGNATURE

By signing below, I certify that (1) the above therapy is medically necessary and in the best interest of the patient listed above; (2) the information provided is complete and accurate to the best of my knowledge; (3) I have obtained any and all authorizations and consents from the patient or the patient's authorized personal representative necessary under HIPAA and state law to release protected health information, including that contained on this form, to Azurity Pharmaceuticals and its affiliates, vendors, and agents for purposes relating to the program and forwarding the above prescription by fax or other means of delivery to a licensed pharmacy to dispense Myhibbin where appropriate; and (4) I have prescribed the medication to this patient based on my professional judgment of medical necessity, for an on-label diagnosis. (5) I will immediately notify Azurity Pharmaceuticals, Inc. if my patient is enrolled in the program and I become aware that their insurance or treatment status has changed. (6) I will not submit an insurance claim or other claim for payment to anyone else, including a third-party payer (private or government) or the patient, and I will forego appeals for any denial of insurance coverage for medication provided by Azurity Pharmaceuticals, Inc. for the patient.

| | |
|---|---|
| **Prescriber Signature:** | **Date:** |

## 7 PATIENT AUTHORIZATION AND CONSENT

**Patient Authorization:** By signing below, I authorize my healthcare providers and their staff, including any specialty pharmacies that dispense my medication, and my health insurer(s)/health plan(s) (collectively, my "healthcare team"), to disclose to Azurity Pharmaceuticals, Inc., its affiliates, vendors, and agents (collectively, "Azurity Pharmaceuticals, Inc."), information related to me and my medical condition and treatment, including but not limited to prescriptions, and my health insurance coverage and claims (collectively, "My Information"), for the purposes of enrolling me in Myhibbin PAP and providing me with certain services and information. Specifically, I authorize such disclosures to Azurity Pharmaceuticals, Inc. to use and share my Information with my healthcare team to: (1) establish my eligibility for insurance to cover Myhibbin™; (2) facilitate my obtaining Myhibbin™; (3) contact me regarding my enrollment and participation in the Program and my use or potential use of Myhibbin™; (4) provide me with information about Myhibbin™ and other products, including promotional and educational communications. I also have reviewed and agree with the Terms and Conditions for the Myhibbin Terms and Fair Credit Reporting Act Authorization for the Myhibbin Patient Assistance Program on page 2 of this form. I understand that the services provided by these programs may be revised, changed, or terminated at any time. I understand that my healthcare providers, health plans, and/or specialty pharmacy(ies) may receive remuneration from Azurity Pharmaceuticals, Inc., in exchange for providing me with support services. I certify that I am at least 18 years old.

| | |
|---|---|
| **Signature of Patient or Legal Representative:** | **Date:** |
| Legal Representative Relationship to Patient: (Complete if legal representative signs above) | Print Name of Legal Representative: |

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Myhibbin™ (mycophenolate mofetil oral suspension)

## Myhibbin™ Patient Assistance Program (PAP) and Fair Credit Reporting Act (FCRA) Authorization

If you, the patient, provide financial information and sign the Patient Authorization and Patient Consent on page 1 of the Myhibbin Enrollment Form, you are seeking eligibility consideration from the Myhibbin PAP, and you understand and agree with these terms and conditions:

- I understand that once my Information has been disclosed as authorized, federal privacy law may no longer restrict its further disclosure to others. I also understand, however, that the PAP plans to use and disclose my Information only for the purposes described or as required by law.
- I understand that my refusal to sign this Authorization will not affect my right to treatment or payment for healthcare and that, if I do sign, I may later withdraw this Authorization by sending written notice of my withdrawal from the Program to the Myhibbin PAP, Azurity 1120 Stevenson Mill Rd Suite 400, Coraopolis, PA 15108; however, such withdrawal will not invalidate uses and disclosures of my Information made prior to the Program's receipt of the withdrawal notice. I am entitled to a copy of this signed Authorization, which expires five (5) years from the date I sign it or at such earlier time as may be required by state law.
- I understand that I am authorizing the Myhibbin PAP, under the FCRA, to obtain information from my credit profile or other information from consumer reporting agencies for the purpose of determining financial qualification for the Myhibbin PAP. I understand that I must affirmatively agree to these terms in order to proceed with this financial screening process. I promise that any information, including financial and insurance information that I provide, is complete and true and, unless I have indicated otherwise, I have no drug insurance coverage, including Medicaid, Medicare, any public or private assistance programs, or other form of insurance. I understand that, upon request, Myhibbin PAP will tell me whether it requested an individual consumer report and the name and address of the agency that furnished it. If my income or health coverage changes, I will call Myhibbin PAP at 1.844.472.2032.
- I also understand that, to qualify for the Myhibbin PAP, I must meet certain income and other eligibility requirements. I confirm my agreement with the conditions and certify that the information I have set forth in this application, including the number of people living in my household and my household income, are true and accurate to the best of my knowledge. I understand that Myhibbin PAP may ask for proof of income at any time for the purpose of an audit or verification. If requested, I agree to provide proof of income within 45 days of the request (change from 30 to 45 and everywhere). Continuation in the PAP is conditioned upon timely verification of income. I certify and attest that I will promptly contact Myhibbin PAP if my financial status or insurance coverage changes.
- I understand that any drugs provided under the Myhibbin PAP shall not be sold, traded, bartered, or transferred. I understand I must be a permanent resident of the U.S. or U.S. territory (including Guam, Puerto Rico, and the Virgin Islands).
- I understand that any program assistance provided by Myhibbin PAP will terminate if the PAP becomes aware of any fraud or if this medication is no longer prescribed for me. I certify that I cannot afford this medication.
- I understand that completing this application does not ensure that I will qualify for Myhibbin PAP.
- I will not seek reimbursement or credit for the medicine(s) from my prescription insurance provider or payer.
- Azurity Pharmaceuticals, Inc. reserves the right to modify or cancel the Myhibbin PAP, or terminate my enrollment, at any time, without prior notice.
- The support provided through Myhibbin PAP is not contingent on any future purchase.



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