fensolvi® (leuprolide acetate) for injectable suspension | fensolvi totalsolutions®

Please FAX Form to: 1-877-991-1798

Phone: 1-833-213-9520
Mon–Fri: 9AM–8PM ET | Sat: 11AM–3PM ET

Patient Assistance Program Form | Page 1 of 3

1. Patient Information

FIRST NAME	LAST NAME	SEX ☐ Male ☐ Female	DOB
ADDRESS 1	ADDRESS 2		
CITY		STATE	ZIP
CAREGIVER/LEGAL REPRESENTATIVE NAME	RELATIONSHIP	SOCIAL SECURITY #	
CAREGIVER/LEGAL REPRESENTATIVE NAME	RELATIONSHIP	SOCIAL SECURITY #	
CAREGIVER PHONE #			

2. Prescriber Information

PRESCRIBER NAME (FIRST)	LAST NAME	SUFFIX
NPI # / TAX ID #	PTAN #	STATE LICENSE #

3. Facility Information

FACILITY NAME

ADDRESS	CITY	STATE	ZIP
CONTACT NAME	PHONE #	FAX #	

Site of care: ☐ Hospital/Outpatient ☐ Ambulatory/Surgical Center ☐ Physician's Office ☐ Other

4. Diagnosis Information

QUANTITY
☐ 1 Injection

ICD-10/Diagnosis Code: ☐ E30.1 ☐ E22.8 ☐ Other:

Do you have the patient's HIPAA consent on file authorizing the release of the patient's identification and insurance information to Tolmar, Inc. and their agents and representatives for benefit verification and patient assistance services?

☐ Yes ☐ No **(Confirmation of written patient HIPAA consent is required for benefits verification & patient assistance services)**

By signing this form I hereby confirm that I have properly obtained the required consent and authorization (if needed) that are required under Federal HIPAA and other State and Federal privacy laws, to release and share certain protected health information to the Tolmar PAP Program managed by its contracted third party ("the PAP"). I further certify that the information provided is complete and accurate to the best of my knowledge.

I verify that I am a practicing healthcare provider, authorized to request, prescribe and receive prescription medications at the address identified herein. I will notify the PAP if any changes occur to my status in this regard. I further verify that I understand the PAP program may make product available to eligible patients (as determined by the PAP), and ship such product to me designated for a specific approved patient's use. I further verify that I am prescribing the medication identified and ordered for my patient through the PAP and will only dispense the product received for the specific patient identified and enrolled in the PAP. I may not dispense or use product provided by the PAP for any other purpose.

I further verify that I shall not bill, sell, seek reimbursement from the government or any third party or file any claim for the drug product provided under the PAP. I also acknowledge that my patient's approval and participation in the PAP was not in exchange for any promise or reward or other explicit or implicit agreement with Tolmar for or relating to past or future use, ordering, prescribing, recommending or referring of any Tolmar products.

Prescriber Return Clause

I confirm and agree that if the patient does not show up for the PAP medication or is otherwise unavailable to receive the product provided by the PAP within 30 days from receiving the PAP drug product, I must contact the PAP and arrange for the return of the product. I will call 1-833-213-9520 to obtain assistance and instructions on PAP returns.

PRESCRIBER SIGNATURE	DATE

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For Ohio Licensed Healthcare Practitioners Only

Please print/type your Terminal Distributor of Dangerous Drug (TDDD) license number (if applicable): _____

Please visit the Ohio State Board of Pharmacy website (www.pharmacy.ohio.gov) for additional information on when a prescriber must hold a TDDD license.

Are you exempt from TDDD licensure? ☐ Yes ☐ No

By checking "Yes," you attest that you meet one of the licensing exemptions under ORC 4729.541. Exemptions include but are not limited to: (1) prescribers who are sole proprietors; (2) business practices with a sole shareholder (per Ohio law, group practices with multiple shareholders are not exempt); and (3) dentists licensed by the Ohio Dental Board. Please visit the Ohio State Board of Pharmacy website for additional information. By checking "No," you attest that you have provided a valid TDDD license number above. Your signature serves as attestation and that you have the appropriate TDDD licensure or qualify under an exemption.

Patient Assistance Program

Total number of people in household: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ Other:		ANNUAL HOUSEHOLD INCOME $
REPRESENTATIVE/ORGANIZATION NAME	RELATIONSHIP	PHONE #

AUTHORIZATION FOR DISCLOSURE OF INFORMATION

This "Authorization" is hereby provided for the purpose of providing permission for the use and disclosure of my protected health information, including but not limited to my name, medication be treated for, application into the Tolmar PAP program, insurance and financial information and other relevant information. I hereby request and authorize my healthcare providers and insurers to disclose any healthcare, treatment, insurance and other information that pertains to my medication to Tolmar, Inc. and its third party vendors ("Tolmar") for the purpose of (a) processing my application for access to the Tolmar Patient Assistance Program ("PAP"); determining my eligibility in the PAP; (c) determining my ongoing eligibility status and future transfers, withdrawals or cancellations, including case reviews, audits, assessments and other verification procedures. Upon receipt of my healthcare information, I hereby authorize Tolmar to disclose such information to my healthcare providers and insurers as necessary to determine my eligibility in the PAP and if approved, to notify of enrollment in the PAP. I understand that my future treatment, prescriptions and medical care from healthcare providers and insurers are NOT contingent upon signing this Authorization and that I am not required to sign this Authorization. However, I understand that if I do not sign this Authorization, I will not be eligible for the PAP. I further understand that I may cancel this Authorization by mailing a letter to the Fensolvi TotalSolutions®, 7515 S. Main St., Suite 180, Houston, TX, 77030. Upon providing such notification, Tolmar may not further disclose my health information and I will not be eligible for the PAP as of the notification date.

This Authorization shall be valid for 10 years from the date set forth below, unless required to be shorter by State Law. Upon signing this Authorization my health information will no longer be protected under HIPAA and is subject to re-disclosure.

PATIENT ATTESTATION FOR MEDICARE OR MEDICAID PRESCRIPTION DRUG PLAN

If I am a member of a Medicare Prescription Drug Plan, I understand that I may be eligible if I am uninsured for the Tolmar PAP, as solely determined by Tolmar.

If I am eligible for a Medicaid Prescription Drug Plan, but that plan does not cover the Tolmar drug products, I may be eligible for the PAP if:

- I agree I will file no claim with any government or commercial insurer for the drug product provided to me under the PAP (e.g. Medicare, Medicaid, Puerto Rico's Government Health Plan Mi Salud, or any Commercial Insurer).
  - I obtain confirmation from Medicaid that it will not cover the Tolmar drug product. (If the Medicaid Program covers a portion of your cost, you will not be eligible for the PAP).
  - If eligible, I have applied for Puerto Rico's Government Health Plan Mi Salud and have been denied.
  - I agree to send notification to my Medicaid provider that I have received free product under the Tolmar PAP in order to ensure that no payment for the product is made under the Medicaid Plan.
- I further verify that if my insurance or financial information changes in any material respect (e.g. change in employment, insurance/medical expenses or total household number), I will immediately notify Tolmar.

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AUTHORIZATION FOR DISCLOSURE OF INFORMATION (continued)

CERTIFICATION FOR PATIENT ASSISTANCE

My signature below confirms that I am applying for free drug product under the Tolmar, Inc. ("Tolmar") Patient Assistance program ("PAP"). I understand that I am not entitled to free product but that I may apply and if eligible, as determined solely by Tolmar, I may receive product at no cost. I understand that Tolmar has no obligation to provide me free product and I hereby waive any and all claims of liability of Tolmar in relation to the PAP program and services provided. I understand that by signing below, I am not guaranteed eligibility. I verify that the information I have provided to the PAP is true and complete to the best of my knowledge. I further verify that if eligible, I will not file any claim or seek any reimbursement for the free product provided to me. I further certify that the prescriber writing the prescription for Tolmar product was selected by me and not referred by Tolmar or any of its agents. If eligible, I understand that Tolmar may terminate eligibility at any time and without any advance notice to me. I further understand, that even after I am determined to be eligible, Tolmar is under no obligation to provide product and may at any time cancel my eligibility for any reason or no reason whatsoever. I further verify that if my insurance or financial information changes in any material respect, I will immediately notify Tolmar.

PRINT PATIENT NAME	If you are signing this Authorization as a personal representative of the person to receive Fensolvi®, please state your relationship (e.g., "mother," "father," "Legal Guardian")
PRINT NAME OF CAREGIVER/LEGAL REPRESENTATIVE	RELATIONSHIP TO PATIENT
SIGNATURE	DATE

Patient Assistance Program

Program Eligibility

- An application must be submitted for each patient
- Patient must be diagnosed with an FDA approved indication for the product
- Patient and caregivers must be a resident of the United States
- Patient must have no insurance coverage
- Patients with Medicare, Medicaid, Mi Salud and other government insurance coverage for Fensolvi® may not be eligible
- Patient must be under the care of a licensed healthcare provider who is authorized to prescribe, dispense, and administer medicine in the US. State Lic.# and DEA are required
- Patient/Caregivers must meet the following financial criteria:
  - Annual household income of ≤500% of current Federal Return Poverty Level (FPL) for oncology/ hematology products
- If there has been a change in status (loss of income, medical expenses, insurance coverage, change in household size) during the tax year, please submit proof of status change for consideration

Documentation Requirements

- Please **complete all sections**
- Please submit a copy of Medicare card or letter of Medicaid and/or Social Security denial, if applicable
- Please **have the caregiver sign the bottom of this form** for the Tolmar Patient Assistance Program
- **Proof of income is required:**
  Submit an acceptable form of income documentation
  (If not required to file a US income tax return,
  IRS Form 4506-T may be required)

1. Copy of W-2 (from all employers) or most recently filed US Income Tax (IRS Form 1040, 1040A, 1040EZ, 1040NR, or 1040PR)
   or
2. Copy of most recent pay stub plus most recent US Income Tax Return,
   or
3. Copy of most recent IRS Form-1099 plus most recent US Income Tax Return,
   or
4. Copy of most recent SSA-1099 plus most recent US Income Tax Return

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