ALLHEALTH NETWORK PATIENT ASSISTANCE PROGRAM

- Please print clearly in blue or black ink
- Please send **copies** of required documents along with application
- Please be sure to complete all information
- Questions? Call **303-797-2500**

1 Patient Information

Name (First, Middle Initial, Last) ☐ Male ☐ Female DOB: Month Day Year Social Security #

Street Address City State Zip Code

( ) Home Telephone ( ) Work Telephone Caregiver Name (First, Last) and Relationship

Is Patient a U.S. Citizen? ☐ Yes ☐ No (If no, please, provide proof of U.S. residency, such as a copy of Green Card or other government issued ID that identifies the patient's address.)

Does the Patient have a valid prescription for a branded medication included in the AllHealth Network Patient Assistance Program? ☐ Yes ☐ No

(If no, please contact your health care provider for a valid prescription for branded product before continuing the application process)

2 Physician Information

Name (First, Middle Initial, Last) ( ) Telephone ( ) Fax

Street Address City State Zip Code

3 Insurance Information

Does the patient have health insurance? ☐ Yes ☐ No

If Yes:

Primary Insurance Company Insurance Telephone ID#

Secondary Insurance Company Insurance Telephone ID#

Has patient applied for Medicaid or other state funded program(s)? ☐ Yes ☐ No (If denied, reason for denial):

Does patient participate in any of the following? Check all that apply:

- ☐ Medicare
- ☐ Medicare HMO or Medicare + Choice or Medicare Advantage
- ☐ Medicare Program for Reimbursed Self-Injectable Drugs
- ☐ Medicaid
- ☐ Any other Federal healthcare program(s), please list:
- ☐ Veterans Administration
- ☐ Indian Healthcare
- ☐ Public Health Services
- ☐ Workman's Compensation
- ☐ TRICARE/CHAMPUS

4 Financial Information

- Please indicate your household size based on IRS Form 1040 or 1040 EZ (number of persons dependent upon total household income):
- Please indicate your household's Adjusted Gross Income as it appears on the most recent year's federal tax return: $
- Please attach a copy of the most recent year's federal tax return (IRS Form 1040 or 1040 EZ) as well as the W2 form(s) that document your household income, or other verifiable financial statements and information. Please note that household income also includes alimony, child support, Social Security, pension or retirement payments, unemployment benefits, workers' compensation, and/or disability payments you receive.

- Please attach a copy of the Medicaid denial letter
- The AllHealth Network Patient Assistance Program application cannot be processed without this documentation.

5 Patient Authorization for Use and Disclosure of Personal Health Information

I authorize my healthcare providers (including pharmacy providers) and health plans to disclose my personal health information ("PHI") (as such term is defined in the Health Insurance Portability and Accountability Act ("HIPAA") and regulations thereunder, as well as other state and/or federally protected personal information), including my personal contact and other information on this form (collectively, my "Information"), to The AllHealth Network Patient Assistance Program Support Center including any third parties engaged to assist the AllHealth Network Patient Assistance Program Support Center (collectively, "Support Center"), in administering the AllHealth Network Patient Assistance Program (the "Program") for the purposes described in this authorization. I understand that the Support Center may disclose my Information to my insurance or other benefit provider, including the Centers for Medicare & Medicaid Services and any authorized vendor(s) of such insurance or other benefit providers, for the purposes of verifying my Medicare Part D or other enrollment status, confirming coverage (or lack thereof) for the requested drug(s), and disclosing my enrollment in the Program with my Medicare Part D plan or other insurance/benefit provider. I understand that my Information may include my name, address, income, prescription coverage, prescription for drug(s), financial documents and insurance records, other information provided on this application, and any information reasonably requested by the Support Center for the purposes of (i) determining my eligibility to participate in the Program, both initially and throughout my participation in the Program, (ii) shipping appropriate drug(s) as prescribed by my licensed prescriber, (iii) communicating with my healthcare providers and health plans about my eligibility for the Program, my benefit and coverage status, and /or my medical care, (iv) reporting safety information, including in communications with the US Food and Drug Administration and other government authorities; (v) contacting me regarding my use or potential use of the product described herein and providing me with related patient support communications, including through messages left for me that disclose that I take or may take the product; and (vi) administering, evaluating, and improving the Program, including by analyzing the usage patterns and the effectiveness of AllHealth Network products, services, and programs and helping develop new products, services, and programs, and for other AllHealth Network general business and administrative purposes. I understand that upon the furnishing of my Information to the Support Center, my Information may not be subject to all of the protections and safeguards provided by HIPAA or other federal and state privacy laws. I understand that I may refuse to sign this Authorization and that doing so will not affect my prescriber's treatment of me or my eligibility for insurance benefits. I also understand that if I refuse to sign this authorization, I may not be able to receive assistance from the Program. I also understand that if I sign, I may later withdraw this Authorization by sending written notice of my withdrawal from the Program to the address set forth herein, and that such withdrawal will not affect any uses and disclosures of my Information prior to the Program's receipt of the notice. I am entitled to a copy of this signed Authorization, which expires in 10 years unless otherwise specified by law.

Patient/Parent/Legal Guardian Signature (original signature required): _____

Date:_____

Power of Attorney: ☐ Yes ☐ No ☐ N/A Power of Attorney (First, Middle, Last): _____

6 Patient Certification

I certify that, as of the date of my signature, the information provided in this application is complete and accurate to the best of my knowledge and that all of the insurance plans and programs through which I obtain health care coverage are listed above or have been provided separately to the Program. I understand that the Support Center is entitled at any time to request verification of any such information which I agree to provide from me, my insurer, and/or other benefit providers; and the Support Center may contact me to, among other things, request such information, verify my application status, and/or confirm my receipt of the drug(s) dispensed through the Program. I understand that completion of this application and the provision of the requested documentation does not guarantee I will be approved for the Program and eligibility is subject to the Program's sole discretion. I understand the Program reserves the right at any time and without notice to me to modify and/or discontinue any or all of the Program. If eligible to receive assistance, I understand there is no purchase requirement associated with such assistance. Further, any product provided to me at no charge will be provided on a complimentary basis; I will not submit or cause to be submitted any claims for payment or reimbursement to any third-party payer, including a Federal health care program for such product; I will not sell, trade, or distribute or otherwise transfer the Program drugs; and the cost of the product will not count toward any Medicare true out-of-pocket ("TrOOP") costs. If approved, as required by my insurance or other benefit provider, I will notify such provider of my receipt of any drug(s) through the Program. The Program does not cover or provide support for supplies, procedures, or any physician related services associated with AllHealth Network patient therapy. I understand that I must re-apply for the Program annually.

Patient Name (please print): _____ Date: _____

Patient Signature (original signature required): _____ Date: _____

(If patient is a minor): Legal Representative Name (please print): _____

Parent/Guardian/Legal Representative Signature: _____ Date: _____

If signed by a Personal Representative, please describe your authority to act on behalf of the patient: _____

Please return the completed application form and required documentation to:

AllHealth Network Patient Assistance Program Coordinator, 5500 S Sycamore St #100, Littleton, CO 80120