

PATIENT ASSISTANCE PROGRAM FORM

*Indicates required field

PATIENT INFORMATION

*Patient Name (Last, First): _____

*Date of Birth: _____ *Gender: M F

*Address: _____

*City: _____ *State: _____ *Zip: _____

*Patient Height: _____ *Patient Weight: _____

*Allergies: _____

*Medication List: _____

*Patient or Legal Representative Name: _____

*Patient or Legal Representative Email: _____

*Patient or Legal Representative Phone: _____

PHARMACY INSURANCE INFORMATION

*Insurance Name: _____ Pharmacy Help Desk #: _____

Policyholder Name: _____ *Relationship to Patient: _____

*Member ID #: _____ *Group ID #: _____

*Rx BIN #: _____ *PCN #: _____

MEDICAL INSURANCE INFORMATION

Primary Insurance: _____ Phone: _____

Member ID: _____ Group ID: _____

Secondary Insurance: _____ Phone: _____

Member ID: _____ Group ID: _____

Prescriber: _____

Please attach insurance card image.

PRESCRIPTION

Drug: **Gleostine (Iomustine)** *Dosage: 10 mg *Quantity: _____
 40 mg *Quantity: _____
 100 mg *Quantity: _____

*Directions: _____

*Refills: _____

*ICD-10/Diagnosis Code: C71 - C71.9 Brain Cancer
 EC81 - C81.90 Hodgkin's lymphoma

*MD Signature _____ *Date _____

PRESCRIBER INFORMATION

*Prescriber Name (Last, First): _____

*NPI: _____

*Prescriber Phone: _____ *Fax: _____

*Address: _____

*City: _____ *State: _____ *Zip: _____

Email: _____

PRESCRIBER OFFICE CONTACT INFORMATION

*Office Contact Name (Last, First): _____

*Email: _____ *Phone: _____

*Fax: _____

*Shipping Address: _____

Do you have the patient's HIPAA consent on file authorizing the release of the patient's identification and insurance information to Azurity Pharmaceuticals, Inc. and their agents and representatives 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 Gleostine Patient Assistance Program (PAP) 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 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 Azurity for or relating to past or future use, ordering, prescribing, recommending or referring of any Azurity 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 (877) 438-9759 to obtain assistance and instructions on PAP returns.

*Prescriber's Signature _____ *Date of Signature _____

PATIENT ASSISTANCE PROGRAM FORM

PROVIDER ATTESTATION

*The patient does not have active insurance YES NO *By checking yes, you attest the patient is uninsured

*The patient has insurance but Gleostine is not covered by patient's insurance YES NO *By checking yes, you attest the patient's insurance does not cover Gleostine

*The patient cannot afford the out-of-pocket cost of Gleostine YES NO *By checking yes, you attest the patient cannot afford their out-of-pocket (OOP) cost of Gleostine

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 Gleostine Patient Assistance 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 Azurity Pharmaceuticals, Inc. and its third party vendors ("Azurity") for the purpose of (a) processing my application for access to the Gleostine 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 Azurity 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 faxing a letter to (877) 619-6574. Upon providing such notification, Azurity 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.

CERTIFICATION FOR PATIENT ASSISTANCE

*Print Patient Name

If You Are Signing This Authorization As A Personal Representative Of The Person To Receive Gleostine[®], Please State Your Relationship (E.g., "Spouse," "Power of Attorney (POA)," "Legal Guardian")

*Print Name Of Patient or Legal Representative

*Relationship To Patient

*Signature

*Date

PATIENT ASSISTANCE PROGRAM TERMS AND CONDITIONS

- Patient and caregiver must be a United States (U.S) citizen or resident and must physically reside in the U.S
- Patient has been prescribed Gleostine for an on-label, FDA-approved indication.
- Prescriber must complete and submit a PAP enrollment form for every patient.
- Patients whose health insurance plan or employer requires them to go through a third-party Alternative Funding Program (AFP) and apply to the PAP as a condition of, requirement for, or prerequisite to coverage of Gleostine will not be eligible for assistance from this program.
- Income criteria that demonstrate qualifying financial needs and proof of income documentation.
- Medical Expenses: Acceptable medical expenses submitted to the program should contain the amount and date of the transaction.

Azurity reserves the right to cancel or modify the program at any time.

DOCUMENTATION REQUIREMENTS

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

PATIENT ASSISTANCE PROGRAM

*Total number of people in household: 1 2 3 4 5 Other:

*Annual Household income \$:

*Representative/
Organization Name

*Relationship

*Phone #

