Validus PHARMACEUTICALS

ENROLLMENT APPLICATION
All fields required
Mail completed application to:

**Validus Pharmaceuticals LLC**
**119 Cherry Hill Rd, Suite 310**
**Parsippany, NJ 07054**

***Program Eligibility:***

- Patient must be a legal resident of the United States.
- Patient cannot be covered or eligible for any government prescription programs such as Medicaid, Medicare Part D, Veteran's Administration, or any State or local programs, either directly or indirectly (through other household members).
- Patient does not have any insurance that will reimburse or otherwise pay for the product.
- Patients must meet specific program criteria; **not everyone who applies will qualify for enrollment. Proof of household income is required with original application and annually thereafter. Documentation of all sources of income is required. (Household income is defined as all sources listed in section E, Eligibility, page 1 of Enrollment Form).**
- Household income must not exceed 200% of the **2017** Federal Poverty Level (FPL) as listed in the chart below:

| Family Size | 200% of 2017 FPL |
|---|---|
| 1 | 24,120 |
| 2 | 32,480 |
| 3 | 40,840 |
| 4 | 49,200 |
| 5 | 57,560 |
| 6 | 65,920 |
| 7 | 74,280 |
| 8 | 82,640 |

**Medications Available Through the Patient Assistance Program Are Subject To Change at Any Time**

***Initial Enrollment Instructions:***

**Patient Instructions**

- Patient must complete and sign pages 1 and 3 of application.
- Attach copy of the patient's household most recent federal tax return and all supporting documentation listed in section E of the form, (W-2 / 1099, social security, disability statement, pension, unemployment, child support statement, etc.) **Updated proof of household income is required annually**.
- If the patient does not file taxes, he/she should submit form 4506-T ("Request for Transcript of Tax Return") **to the IRS** requesting Verification of Non-filing (item # 7). (DO NOT SEND FORM 4506-T TO VALIDUS). The IRS will then forward a letter back to the patient/taxpayer (usually within 10-days) verifying non-filing of taxes. Once the letter of reply from the IRS is received by the patient/taxpayer it must be mailed to Validus Pharmaceuticals LLC as proof of non-tax filing.

**Practitioner Instructions**

- "Practitioner" section (page 2 of form) must be completed with original signature of authorized physician.
- Attach an original prescription of the medication, written for a **three-month supply,** to the application.
- **NO AUTOMATIC REFILLS.**

**Both the patient and the practitioner will be advised in writing of any denied applications or additional information requests. Incomplete applications will be returned to the practitioner for completion.**

***Continuing Enrollment Instructions:***

- Patient "Information & Eligibility" section (page 1 of form) must be completed and must include original signatures.
- "Practitioner" section (page 2 of form) must be completed with original signature of authorized physician.
- Attach an original prescription of the medication, written for a **three-month supply** to the application. **NO REFILLS**.
- **Mail original application and original prescription to the address listed above.**
- **Proof of household income must be verified annually.**

Validus
PHARMACEUTICALS

## Patient Assistance Program – Enrollment Form
## Section 1: Patient Information

Patient's Name:_____
(Last) (First) (M.I.)

Address:_____

City:_____ State:_____ Zip:_____

SS#_____

Date of Birth_____

Marital Status_____

Phone_____

**IF ALL INFORMATION IS NOT CLEAR AND COMPLETE, THIS FORM WILL BE RETURNED**

### Eligibility

A. Is the patient a legal U.S. resident? ☐ Yes ☐ No

B. Is the patient directly or indirectly (through other household members) covered or eligible for prescription coverage in any government program (i.e. Medicaid, Medicare Part D, VA or any other state or local program)? ☐ Yes ☐ No

C. Is the patient enrolled in Medicare Part D? ☐ Yes ☐ No

D. Is the patient directly or indirectly (through other household members) covered or eligible for prescription coverage with any private programs (i.e. private insurance HMO plan, PPO plan)? ☐ Yes ☐ No

E. List all Sources of Income, **Gross Monthly Amounts**: (Submit documentation of all sources of income with application.)

| | | | |
|---|---|---|---|
| Salary/Wages | $_____ | Social Security | $_____ |
| Social Security Disability | $_____ | Pension/Retirement | $_____ |
| Child Support/Alimony | $_____ | Unemployment/Workers Comp | $_____ |
| Investment income | $_____ | | |

| Prescription Drug Coverage (check box) | | |
|---|---|---|
| Prescription Drug Coverage: Private/Commercial Insurance | Yes ☐ | No ☐ |
| Medicaid Drug Coverage | Yes ☐ | No ☐ |
| Medicare Drug Coverage/ Medicare Part D | Yes ☐ | No ☐ |
| State Drug Assistance | Yes ☐ | No ☐ |

F. Total **ANNUAL** household income; including social security and pension benefits, must **NOT** exceed **200% of Federal Poverty Level** (see chart under Program Eligibility). $_____

G. Number of persons residing in household (including patient). _____

Patient Signature (must be original – no photocopies) Date

***PATIENT DECLARATION – PLEASE READ AND SIGN***

I verify that the information provided in this application is complete and accurate. I authorize Validus Pharmaceuticals LLC to use this information to assess my eligibility for participation in the Patient Assistance Program ("Program"), including the audit of my medical records and/or by contacting my health care provider, my insurance company or me directly to confirm my eligibility or receipt of drug or matters related to such program. I understand that this assistance is temporary and that this Program may be discontinued or changed at any time. I understand that Validus Pharmaceuticals LLC will use my personal information in connection with the operation of the Program and issues related to the Program. I certify that I do not have the ability to pay for my medication, earn less than 200% of the current HHS Poverty Guidelines, am a U.S. resident, and that I have no government or private insurance to pay for my medication. I also certify that I do not have other sufficient financial resources or assets to pay for the medication requested or that paying for the medication from my own resources or assets would cause me severe financial hardship. I understand that I am expected to seek any available State or government assistance before applying or reapplying to the Validus Pharmaceuticals Patient Assistance program. I agree to notify Validus if my insurance coverage or financial situation changes. I agree not to submit an insurance claim or any other claim for payment to any third party payor (private or government) for the prescription product. I agree not to resell, offer for sale, trade or barter, or return for credit the prescription product and that it will be utilized solely for my personal use. I understand that I will be deemed ineligible to participate in the Program if I provide any incorrect or false information to Validus Pharmaceuticals LLC. I have read and agree to all terms of the Patient Declaration on this application. I attest the information I have provided is correct and complete.

Signed Date

Validus
PHARMACEUTICALS

**Patient Name** _____

**IF ALL INFORMATION IS NOT CLEAR AND COMPLETE, THIS FORM WILL BE RETURNED**

## Section 2: Practitioner Information

Practitioner's Name:_____
(Last) (First) (M. I.)

Address:_____

_____

City:_____ State:_____ Zip:_____

Phone #_____

Fax #_____

DEA #_____
If no DEA# is available, please attach a copy of State license.

NPI#_____

I represent that the information contained in this application is complete and accurate to the best of my knowledge. I certify that the use of the indicated medication is medically necessary and I will be evaluating the patient's treatment. To the best of my knowledge, this patient has no prescription insurance coverage for the indicated medication, including Medicaid, Medicare Part D or other public programs, and the patient has insufficient financial resources to pay for the prescribed therapy. I acknowledge and agree not to submit any insurance claim or other claim for payment to any third-party payor (private or government) for the prescription product, and I cannot charge a fee for professional services, or any other services rendered in association with the prescription of the product. I understand that Validus Pharmaceuticals LLC reserves the right to modify or terminate this program at any time or to refuse to distribute the medication under this program to any patient or physician. Validus Pharmaceuticals LLC also reserves the right to modify the financial eligibility criteria at any time. My signature certifies that goods received from Validus Pharmaceuticals LLC are for the use of the above named patient only. These goods will not be resold nor offered for sale, trade or barter and will not be returned for credit. Validus Pharmaceuticals LLC reserves the right to recall the product when necessary.

I also represent that I am in good standing in my state where I hold my medical license. I further represent that I have not been excluded from participating in federally funded health care program pursuant to 42 U.S.C.. § 1320.

_____

Signature of Licensed practitioner (Must be original - No stamped signatures or photocopies) Date

All information in this application will be kept confidential to the patient as permitted by law and regulation.

Validus
PHARMACEUTICALS

## Patient Assistance Program Authorization Form

This Patient Assistance Program Authorization Form authorizes your health care provider to disclose your health and medical information to Validus Pharmaceuticals LLC and their respective employees, representatives and agents or its suppliers (collectively, "Validus") in connection with your application to the Patient Assistance Program ("PAP") as required by the Health Insurance Portability and Accountability Act of 1996 and related federal regulations and rules ("HIPAA").

Authorization

I, _____ **[First, Middle and Last Name]**, hereby authorize _____**[Name of Physician or Medical Group] ("Health Care Provider")** to disclose my individually identifiable health and medical information described below to Validus solely for the authorized purpose described in this authorization form.

Description of Health and Medical Information That May Be Disclosed

My Health Care Provider may disclose individually identifiable health and other information that supports my application to the PAP and may include my name, address, date of birth, social security number, financial information, medical records and the specialty of my Health Care Provider.

Authorized Purposes

The authorized purposes are: (1) to permit Validus to evaluate my eligibility for participation in the PAP, and (2) if Validus, in its sole discretion, approves my request to participate, for Validus' administration of my participation in the PAP.

Expiration of Authorization

My authorization shall expire (1) when Validus does not approve my application for participation in the PAP, or (2) at the conclusion of my participation in the PAP, whichever is earlier.

Acknowledgements

(1) I understand that Validus is not an entity covered by HIPAA and related federal privacy regulations and that my medical and health information may be subject to disclosure by Validus and no longer protected by such federal privacy regulations. I further understand and agree that Validus may retain my medical and health information as disclosed to Validus by my Health Care Provider under this authorization after this authorization expires for purposes related to the administration of the PAP.

(2) I understand that I may refuse to sign this authorization form and that, unless allowed by law, my refusal to sign will not affect my ability to obtain treatment from my Health Care Provider; or to seek payment or my eligibility for benefits. However, I understand that I may not participate in the PAP if I refuse to sign this authorization form.

(3) I understand that I may revoke my authorization at any time by providing a written notice of same to my Health Care Provider that refers to (or with a copy of) this authorization form, or as set forth in my Health Care Provider's Notice of Privacy Practices (if any). However, I understand that if I revoke this authorization, it will not affect prior disclosures made by my Health Care Provider to Validus in reliance on this authorization. This authorization will expire at the end of my participation in the PAP, unless a shorter period is required by state law.

| | |
|---|---|
| Patient Signature: | Date: |
| Patient Name: | |
| Personal Representative Signature (if applicable): | Relationship of Personal Representative to Patient: |
| ☐ I acknowledge that I am the Personal Representative of the Patient, under applicable state law (PLEASE CHECK BOX IF SIGNING AS PERSONAL REPRESENTATIVE | |

**Health Care Provider Must Give Patient and/or Patient's Representative A Signed Copy**

**Health Care Provider has verified Patient Representative's authority to act on Patient's behalf_____(check)**