

PATIENT ASSISTANCE PROGRAM Enrollment Form

1 PATIENT INFORMATION (*REQUIRED)

QUESTIONS? Call 833-378-3674, Monday through Friday, 8:00 am to 8:00 pm ET.

First Name* _____ MI _____ Last Name* _____
Date of Birth (mm/dd/yyyy)* _____ Gender: ☐ Male ☐ Female ☐ Other
Address* _____ City* _____ State* _____ ZIP* _____
Primary Phone* _____ ☐ H ☐ M ☐ W Best Time to Contact: ☐ Morning ☐ Afternoon ☐ Evening
Email _____ Preferred Language if not English _____
Caregiver Name _____ Caregiver Phone _____

2 INSURANCE INFORMATION (*REQUIRED)

Prescription Insurance Type*: ☐ Commercial ☐ Medicaid ☐ Medicare Part D ☐ Medicare Advantage
☐ Other _____ ☐ None
Prescription Insurance Policyholder First Name _____ Last Name _____
Prescription Insurance Name _____ Prescription Insurance Phone _____
Prescription Insurance BIN _____ Prescription Insurance PCN _____

3 PATIENT ASSISTANCE PROGRAM ELIGIBILITY (*REQUIRED)

Patient Household Size* _____ Patient Household Income* _____

4 PRESCRIBER INFORMATION (*REQUIRED)

First Name* _____ Last Name* _____
Site Name _____
Address* _____ City* _____ State* _____ ZIP* _____
Primary Phone* _____ Primary Fax* _____
NPI* _____ Tax ID _____

5 PRESCRIPTION (*REQUIRED)

Primary Diagnosis* _____ Prescription Product* _____
Prescription Quantity* _____ Prescription Sig/Directions* _____
Prescription Refills _____

6 CONSENTS/AUTHORIZATIONS/SIGNATURES (*REQUIRED)

Patient Fair Credit Reporting Act (FCRA) Consent

Signature* _____ Name (please print)* _____ Date* _____

Patient Health Insurance Portability and Accountability Act (HIPAA)

Signature* _____ Name (please print)* _____ Date* _____

Prescriber Health Insurance Portability and Accountability Act (HIPAA)

Signature* _____ Name (please print)* _____ Date* _____

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7 PATIENT AUTHORIZATION CONSENT

I hereby authorize and direct my health care providers, pharmacies, and health insurers, and their respective staff and service providers (“Health Care Entities”) to use and disclose the following information (“Personal Information”) about me in their possession to Amneal Pharmaceuticals and its representatives, affiliates, contractors, agents, vendors, and partners (collectively “Amneal Pharmaceuticals Entities”):

- Information regarding my medical condition and treatment, including relevant diagnoses and prescriptions (including fill and refill information);
- Information about my health insurance benefits, including deductibles and out-of-pocket costs; and
- All information about me included in this form.

I understand that the purpose of this disclosure is so that Amneal Pharmaceuticals Entities may use and further disclose my Personal Information for the following purposes:

- (1) verifying, investigating, coordinating, and resolving insurance coverage or reimbursement inquiries and payment for Amneal Pharmaceuticals products;
- (2) operating, administering, enrolling me in, and/or continuing my participation in the Amneal Pharmaceuticals program or any other Amneal Pharmaceuticals-affiliated patient support services and activities (the “Patient Support Programs”) related to my condition or treatment including, but not limited to, financial assistance programs such as commercial co-pay and/or patient assistance programs, drug coverage verification, patient education services, adherence programs, and disease management support;

(3) coordinating my receipt of and payment for Amneal Pharmaceuticals products;

(4) utilizing a third-party financial screening tool (eg, Experian or TransUnion), to determine eligibility for financial assistance or free drug programs;

(5) contacting me about the Patient Support Program (including sending me supplemental educational materials, information, offers and services related to my treatment or my medical condition, or communicating with me to facilitate fulfillment of my prescribed medication[s]);

(6) contacting and providing my Personal Information to Health Care Entities, patient advocacy organizations, patient assistance programs, co-pay assistance or similar programs to determine eligibility for coverage and enrollment;

(7) managing the Patient Support Program, including evaluating the effectiveness of the Patient Support Program and for administrative purposes;

(8) de-identifying my Personal Information by aggregating it for research purposes; and

(9) as otherwise permitted by law.

I authorize my Health Care Entities to disclose my Personal Information to the Amneal Pharmaceuticals Entities only for the purposes stated above in this Authorization. I understand that my Health Care Entities may receive payment from Amneal Pharmaceuticals Entities in exchange for disclosing my Personal Information.

8 FAIR CREDIT REPORTING ACT (FCRA) AUTHORIZATION

I understand that I am providing “written instructions” authorizing Amneal Pharmaceuticals and its vendors, under the FCRA, to obtain information from my credit profile or other information from the vendor, solely for the purpose of determining financial qualifications for programs administered by Amneal Pharmaceuticals, including the “Patient Support Programs.” I understand that I must affirmatively agree to these terms in order to proceed in this financial screening process.

9 TELEPHONE CONSUMER PROTECTION ACT (TCPA) CONSENT

I consent to receive marketing and non-marketing calls and texts from and on behalf of Amneal Pharmaceuticals, made with an autodialer or prerecorded voice, at the phone number(s) provided. I understand that my consent is not required or a condition of purchase. The number of messages will vary based on your program selections. Message and data rates may apply. Review our Privacy Policy at <https://amneal.com/internet-privacy-policy/>. Text STOP to opt out and HELP for help. I also agree to be contacted by Amneal Pharmaceuticals and others on its behalf by telephone calls and text messages made by or using an automatic telephone dialing system or prerecorded voice, at the number(s) provided by the “Patient Support Programs,” for all non-marketing purposes, including but not limited to sending me materials and asking for my participation in surveys.

10 PRESCRIBER CONTENT

My signature above certifies that the person named on this form is my patient, the information provided, to the best of my knowledge, is complete and accurate, and that therapy with Brekiya is medically necessary. I authorize the “Patient Support Programs” to transmit the above prescription to the appropriate specialty pharmacy for my patient. I understand that I am under no obligation to prescribe any Amneal Pharmaceuticals products and that I have not received nor will I receive any benefit from Amneal Pharmaceuticals for doing so. I will not seek reimbursement from any third-party payer or government entity for any product provided free of charge by Amneal Pharmaceuticals. Prescribers in all states must follow applicable laws for a valid prescription. For prescribers in states with official prescription form requirements, please submit an actual prescription along with this enrollment form.

I certify that I have obtained all necessary consents, authorizations and permissions, including from my patient, required by applicable state and federal laws to release the individually identifiable health information included on this form to Amneal Pharmaceuticals to use such information for purposes of verifying my patient’s insurance coverage and eligibility; coordinating the dispensing of my patient’s prescription medicine; and introducing Amneal Pharmaceuticals support services to my patient, including contacting my patient by telephone or mail for these purposes.

