brekiya®
(dihydroergotamine mesylate)
1 mg/mL injection
autoinjector

Patient Assistance Program Overview

THE AMNEAL PATIENT SUPPORT SERVICES

Patient Assistance Program

Eligible patients have the opportunity to apply to receive up to one year of Brekiya autoinjector for free through the Patient Assistance Program. To be eligible to receive free medication from Amneal, patients must be residents of the US, Puerto Rico, or US Virgin Islands, not have affordable coverage for their prescription, have diagnosis indicated for the FDA-approved medication, and have a total household income that meets our program's eligibility requirements.

To be considered for the Patient Assistance Program, please complete the application on the following pages. Patients must satisfy the financial and eligibility requirements stated above.

This form serves as an application for the **Patient Assistance Program** only.

Brekiya autoinjector is available for prescription only.

PATIENT ASSISTANCE PROGRAM
Instructions

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Thank you for your interest in Amneal's Patient Assistance Program. This program is for Brekiya autoinjector. Attached is the enrollment form for the Patient Assistance Program.

FOR PATIENTS — Application instructions

Complete all 4 of the following sections:

- **Patient information (Section 1)**
  Note: Upon approval, medication will be shipped to the patient's address
- **Insurance information (Section 2)**
  Include copies of **front** and **back** of insurance card for each type of insurance
- **Patient Assistance Program eligibility (Section 3)**
- **Patient authorization (Section 7)**

FOR PRESCRIBERS — Application instructions

Have the patient complete the Patient Information sections 1, 2, 3, and 7, and sign the application for authorization.

Complete all 4 of the following sections:

- **Prescriber information (Section 4)**
  Please provide phone, fax, State License Number or NPI
- **Prescription information (Section 5)**
- **Clinical information (Section 6)**
- **Prescriber authorization (Section 7)**
  This can be found below the patient authorization

Fax or mail the application to:

Amneal Patient Assistance Program
PO Box 5490
Louisville, KY 40255
Phone: 833-378-3674 Fax: 866-208-5828

If the Patient Assistance Program application is approved, patients are eligible to receive free medication for up to one year. Medications will be shipped to the patient's home. The Patient Assistance Program will send an application for renewal when a patient's enrollment is due to expire.

Please call 833-378-3674 for questions regarding this program or application,
Monday through Friday, 8:00 am to 8:00 pm ET, excluding holidays.

PATIENT ASSISTANCE PROGRAM
Enrollment Form

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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 FOR PRESCRIBERS ONLY: PRESCRIPTION (*REQUIRED)

Primary Diagnosis* _____ **Prescription Product*** Brekiya autoinjector

Prescription Quantity *(there are 4 autoinjectors per carton)** _____ **Prescription Sig/Directions*** _____

Prescription Refills _____ Other _____

6 FOR PRESCRIBERS ONLY: ICD-10-CM CODES

	Code	Description
☐	**G43.0**	Migraine without aura
☐	**G43.1**	Migraine with aura
☐	**G43.9**	Migraine, unspecified
☐	**G44.001**	Cluster headache syndrome, unspecified, intractable
☐	**G44.009**	Cluster headache syndrome, unspecified, not intractable
☐	**G44.011**	Episodic cluster headache, intractable
☐	**G44.019**	Episodic cluster headache, not intractable
☐	**Other**	

Notes:

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Enrollment Form

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7 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*

8 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.

9 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.

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10 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 program selection. Message and data rates may apply. Review the 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.

11 PRESCRIBER CONSENT

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 autoinjector 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.

Amneal

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