

| Phone: 888-417-5780 | Fax: 877-427-7290 | M-F, 8AM to 5PM EST |

# Please complete application in full, sign and date, then fax to: 877-427-7290

Or email to: ViatrisPAP@viatris.com

- The PAP Application must be complete to be reviewed for patient program eligibility. Please ensure all areas of the form are completed in full, including all signatures.
- To be considered for the Viatris Patient Assistance Program, all applicants must satisfy the following requirements and eligibility criteria:
  - o Applicants qualify for the program financial requirements.
  - o Applicants must be a current United States resident (includes U.S Territories).
  - Applicant must be fully uninsured or if insured, have no prescription drug insurance.
  - The requested product must be prescribed by a licensed U.S. healthcare professional for a Food and Drug Administration (FDA) approved indication.
- Each applicant will be individually assessed for program eligibility based on the information provided within this application.
- Applicants will only be evaluated for eligibility upon receipt of a completed and signed Viatris Patient Assistance Program (PAP) Application.





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Patient Information				
Name: First Address*				
Home Phone: Ce	Cell Phone: Patient Email Address:			
Preferred Contact: Cell Phone Home	Phone	e to Call:  Morning	☐ Afternoon ☐ Evening	Gender:
Insurance: Uninsured Commercia	al Government Oth	her	Rx Coverage: Yes	□ No
Insurance Name:	Insurance ID Number:		*No F	PO Boxes Accepted
Prescriber Information				
Prescriber Name:			Prescriber NPI:	
Facility Name:			State License #:	
Facility Address:		City:	State:	ZIP:
Primary Office Contact:			Fax Number:	
Phone Number:	Office Contact Email:			
Prescriber Shipping Address (C	nly complete if shipping	address is differe	nt than address listed a	bove)
Prescriber Name:			Facility Name:	
Shipping Address:		City:	State:	ZIP:
Shipment Contact Name:				
Phone Number:	Contact Email:			



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**Ohio Prescriber Mandatory Subsection** (Select an option below, complete the related fields, then sign & date)

#### MANDATORY SUBSECTION FOR ALL OHIO HCPs

er Ohio law, Mylan Pharmaceuticals Inc., a Viatris Company, may only provide prescription drugs to a prescriber whose practice is licensed as rminal Distributor of Dangerous Drugs ("TDDD") or is exempt from such licensure under Ohio Revised Code ("ORC") § 4729.541. A TDDD see allows a business entity to receive, purchase, and possess prescription drugs, including drug samples, for distribution to patients. For more mation on TDDD licensing requirements for prescribers, please visit the Ohio Board of Pharmacy website at <a href="mailto:pharmacy.ohio.gov/PrescriberTDDD">pharmacy.ohio.gov/PrescriberTDDD</a> , and for a list of exemptions, please refer to section 4729.541 of the ORC. The above information is grovided for your convenience and is not offered, nor should it be construed, as legal advice.
se select and complete one of the following and sign below:
The shipping address I provided above for the following practice, has an active TDDD license that
allows me to receive and store the requested prescription drug products at this location. The TDDD license number isand expires on
OR-
The shipping address I provided above for the following practice, is subject to one of the TDDD licensing exemptions in ORC § 4729.541.
gning below, I warrant that the information provided above is complete and accurate and attest that I can receive and store the requested cription drug products at the shipping address I provided because I hold an unrestricted, active TDDD license or my practice is exempt from ning a TDDD license under ORC § 4729.541.
criber Signature: Date:
(Original signature -and- date required, stamped signatures not accepted)

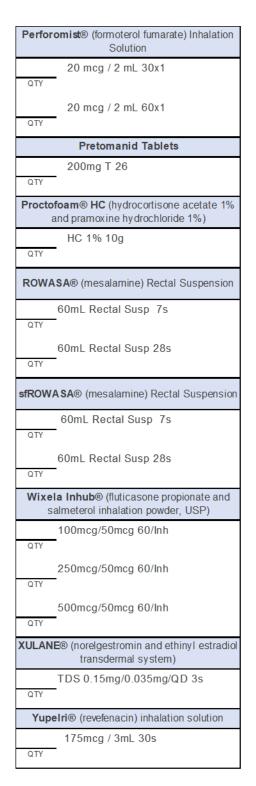






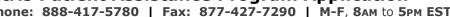
Arixtra® (fondaparinux sodium) injection, solution				
2.5mg/0.5mL PFS 10PK				
5mg/0.4mL PFS 10PK				
7.5mg/0.6mL PFS 10PK				
10mg/0.8mL PFS 10PK				
BREYNA® (budesonide and formoterol fumarate dihydrate) Inhalation Aerosol				
80mcg/4.5mcg				
160mcg/4.5mcg				
Cortifoam® (hydrocortisone acetate 10%) rectal foam				
10% 15g				
Cystagon® (Cysteamine bitartrate) capsules				
50mg C 500s				
150mg C 500s				
Denavir® (penciclovir) Cream				
1% 5gm				
Dipentum® (olsalazine sodium) capsule				
250mg C 100s				
Dymista® azelastine hydrochloride & fluticasone propionate) nasal spray				
137/50mcg Nasal Spray 23g				

EMSAM® Transdermal System				
12 mg/24 hr Bx30				
QTY				
6 mg/24 hr Bx30				
QTY				
TDS 9 mg/24 hr Bx30				
ERMEZA™ (levothyroxine sodium) oral solution				
150 mcg/5mL 150mL				
QTY				
150 mcg/5mL 75mL				
Felbatol® (felbamate)				
400mg T 100s				
600mg T 100s				
Gastrocrom® (cromolyn sodium, USP) oral concentrate				
100mg 5mL Oral Concentrate 96s				
QTY				
Miacalcin® Injection				
200 IU/mL 2mL MDV 1pk				
QTY				
Muse® (alprostadil) urethral				
250mcg Suppository 6s				
QTY				
500mcg Suppository 6s				
1000mcg Suppository 6s				
56.11				





## Viatris Patient Assistance Program Application | Phone: 888-417-5780 | Fax: 877-427-7290 | M-F, 8AM to 5PM EST





Prescription Details- Please complete all releva	ant prescription details below
Patient Name:	Patient DOB:
Prescriber Name:	Prescriber NPI:
Day Supply:	Refills:
Directions:	
Prescriber Certification and Prescription Sign	ature
product I have prescribed to the applicant within this applic Administration (FDA) approved indication, and that I will super	Program Application is complete and accurate to the best of my knowledge, that the Viatris ration is based on my professional judgment of medical necessity for a Food and Drug vise the patient's medical treatment. I will notify Viatris PAP immediately if the Viatris product certify that I have obtained from my patient all required written authorizations for the release on to Viatris and their agents and representatives.
By signing below, I attest that I can prescribe, receive, store, a provided above that will receive the product, hold all required	and dispense the Viatris product and that I, and the facility located at the shipping address I state licenses to receive, store, and dispense the product.
and representatives to verify my patient's insurance coverage	gents and representatives is for the sole use of Viatris and their agents, service providers, e status, to assess the patient's eligibility for participation in the Viatris Patient Assistance ster the product and related services. I understand that application to the Program does not
patient may no longer be eligible for the Program, and I agrepatient's financial and/or insurance status. I agree that Viatris mail and/or telephone. I understand that I am under no obligati	at any time. I understand that if my patient's financial and/or insurance status changes, the se to immediately notify a Viatris PAP representative if I become aware of changes in the PAP may contact me for additional information relating to this application either by fax, e-on to prescribe any Viatris product and that I have not received, nor will I receive, any benefit Viatris product. I agree that I will not sell, submit claims or make any attempt to receive by the Program.
using the Surescripts network. Surescripts requires that Pres	n and enrollment process, United BioSource Corporation (UBC) performs eligibility screening criber agree to comply with all Surescripts' terms and conditions, including confidentiality, s, and use of data. All Surescripts disclaimers apply. A full list of terms and conditions is
of Viatris to use and disclose as necessary for verification of p	orize the release of medical and/or other patient information to agents and service providers atient eligibility, and to furnish any information on this form to the insurer of the applicant for rogram duration per eligibility period is 12 months, and the maximum number of refills per
Prescriber Certification & Prescription Signature:	Date:



(original signature required)



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#### **Patient Authorization and Agreement Signature**

By signing this Authorization, I authorize each of my physicians, pharmacists, including any non-commercial pharmacy that receives my prescription ("my Prescribed Product"), and other healthcare providers (together "Healthcare Providers") and each of my health insurers, if any (together, "Insurers") to disclose my Protected Health Information, including but not limited to medical records, information related to my medical condition and treatment, my health insurance coverage, my name, address, telephone number, Social Security number, insurance plan and or group numbers (together, "Protected Health Information") to Viatris, its affiliated companies, vendors, agents, collaboration partners, and representatives (together, "Viatris") including providers of alternate sources of funding for prescription drug costs, and other service providers supporting the Viatris Patient Assistance Program (PAP) (collectively, the "Program") for the purposes described below.

Specifically, I authorize disclosure of my Protected Health Information in order to:

- I. Enroll me in, and contact me about the Program, including online support, financial assistance services, and co-pay assistance services, as applicable,
- II. Communicate with my Healthcare Providers and Insurers about benefits, coverage, and medical care, including compliance with Product treatments,
- III. Facilitate dispensing of my prescription by a non-commercial pharmacy,
- IV. Provide me with educational materials, information and services related to my treatment experience with my prescribed medication and my condition,
- V. Verify, investigate, and coordinate with my Insurers regarding my prescribed medication, and
- VI. Contact me as otherwise required or permitted by law.

Once my Protected Health Information has been disclosed to Viatris, I understand that federal privacy laws no longer protect the information. However, Viatris agrees to protect my Protected Health Information by using and disclosing it only for the purposes described in this Authorization or as permitted by law. I understand that I may refuse to sign this Authorization. My choice about whether to sign will not change the way my Healthcare Providers or Insurers treat me, but I will not have access to the Viatris Patient Assistance Program and the services provided by Viatris under the Program. If I refuse to sign the Authorization, or revoke my Authorization later, I understand that this means I will not be able to participate in or receive assistance from the Program.

I understand that my signed Authorization is valid for 5 years from the date of my signature, and that I may revoke this Authorization at any time in the future, except to the extent that actions have been taken in reliance on the Authorization. I understand that to revoke this Authorization I may mail a request to 5005 Greenbag Road Morgantown, WV 26508, fax to 877-427-7290, or by calling 888-417-5780. I understand that revoking this Authorization will end further uses and disclosure of my Protected Health Information by the parties identified above except to the extent those uses and disclosures have been made in reliance upon this Authorization as permitted by applicable law. I am entitled to receive a copy of this Authorization.

I understand that if I qualify and I am enrolled in the Program sponsored by Viatris, I will receive my Prescribed Product from Viatris only pursuant to a legally valid prescription from my health care provider. I understand that if I qualify and I am enrolled in the Program, Viatris will provide me my Prescribed Product free of charge for the duration of the enrollment period so long as I have a legally valid prescription for my Prescribed Product. I understand that I am not required to continue treatment with my Prescribed Product if I gain insurance coverage, or to receive treatment from any given provider. I understand and agree that I must notify Viatris PAP at 888-417-5780 immediately if my insurance status changes during the Program enrollment period. I understand and agree that neither I nor my Insurers, if applicable, will be charged for the supply of my Prescribed Product that I received from the Program, and that under NO circumstances may I claim reimbursement from my Insurers or any other third party for the Prescribed Product provided to me free of charge from the Program. I understand that Viatris reserves the right at any time without notice to modify or discontinue the Program and its criteria.

I understand that I am providing 'written instructions' to Viatris under the Fair Credit Reporting Act authorizing Experian on behalf of Viatris to obtain information from my credit profile or other information from Experian. I authorize Viatris and its service providers to obtain such information solely for the purpose of determining financial qualifications for the Program. I understand that I must affirmatively agree to the terms in this notice by signing below in order to proceed in the Program financial screening process.

My signature certifies that I have read and understand the above statements and agree to the outlined terms.

Patient Name (Print):	Patient Signature	Date:	_
Patient Authorized Representa	ative		
	uestions, any missing documentatio	ing person about this application form. This includes discussing the status on and other issues related to my enrollment, or any other treatment-related by time by calling: 888-417-5780	
Name of Authorized Representative:		Relationship to Patient:	_
Telephone Number:	Email:		_
By signing below, I, the patient, allow this	representative to speak on my beha	lf on any matter regarding my enrollment with the Program.	
Patient Signature:		Date:	

