



## **Viatis Patient Assistance Program (PAP) Application**

**| 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: [ViatisPAP@viatis.com](mailto:ViatisPAP@viatis.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 Viatis Patient Assistance Program, all applicants must satisfy the following requirements and eligibility criteria:
  - Applicants qualify for the program financial requirements.
  - 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 Viatis Patient Assistance Program (PAP) Application.

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## Patient Information

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN: \_\_\_\_\_  
First Last Mo Day Year (Required)  
Address\* \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Patient Email Address: \_\_\_\_\_  
Preferred Contact: ☐ Cell Phone ☐ Home Phone ☐ Email Best Time to Call: ☐ Morning ☐ Afternoon ☐ Evening Gender: \_\_\_\_\_  
Insurance: ☐ Uninsured ☐ Commercial ☐ Government ☐ Other Rx Coverage: ☐ Yes ☐ No  
Insurance Name: \_\_\_\_\_ Insurance ID Number: \_\_\_\_\_ \*No 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 *(Only complete if shipping address is different than address listed above)*

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**

Under Ohio law, a licensed manufacturer, outsourcing facility, third-party logistics provider, repackager, or wholesale distributor, may only provide prescription drugs to a prescriber whose practice is licensed as a Terminal Distributor of Dangerous Drugs ("TDDD") or is exempt from such licensure under Ohio Revised Code ("ORC") § 4729.541. A TDDD license allows a business entity to receive, purchase, and possess prescription drugs, including drug samples, for distribution to patients. For more information on TDDD licensing requirements for prescribers, please visit the Ohio Board of Pharmacy website at [www.pharmacy.ohio.gov/PrescriberTDDD](http://www.pharmacy.ohio.gov/PrescriberTDDD), and for a list of exemptions, please refer to section 4729.541 of the ORC. The above information is being provided for your convenience and is not offered, nor should it be construed, as legal advice.

**Please 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 is \_\_\_\_\_ and 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.

By signing below, I warrant that the information provided above is complete and accurate and attest that I can receive and store the requested prescription drug products at the shipping address I provided because I hold an unrestricted, active TDDD license or my practice is exempt from obtaining a TDDD license under ORC § 4729.541.

**Prescriber Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
*(Original signature -and- date required, stamped signatures not accepted)*



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<b>Arixtra® (fondaparinux sodium) injection, solution</b>	
_____	2.5mg/0.5mL PFS 10PK
QTY _____	
_____	5mg/0.4mL PFS 10PK
QTY _____	
_____	7.5mg/0.6mL PFS 10PK
QTY _____	
_____	10mg/0.8mL PFS 10PK
QTY _____	
<b>BREYNA® (budesonide and formoterol fumarate dihydrate) Inhalation Aerosol</b>	
_____	80mcg/4.5mcg
QTY _____	
_____	160mcg/4.5mcg
QTY _____	
<b>Clozapine Tablets, USP</b>	
_____	25mg T 100s
QTY _____	
_____	50mg T 100s
QTY _____	
_____	100mg T 100s
QTY _____	
_____	200mg T 100s
QTY _____	
<b>Clozapine Orally Disintegrating Tablets</b>	
_____	25mg ODT
QTY _____	
_____	100mg ODT
QTY _____	
<b>Cortifoam® (hydrocortisone acetate 10%) rectal foam</b>	
_____	10% 15g
QTY _____	
<b>Cystagon® (Cysteamine bitartrate) capsules</b>	
_____	50mg C 500s
QTY _____	
_____	150mg C 500s
QTY _____	

<b>Denavir® (penciclovir) Cream</b>	
_____	1% 5gm
QTY _____	
<b>Dipentum® (olsalazine sodium) capsule</b>	
_____	250mg C 100s
QTY _____	
<b>Dymista® azelastine hydrochloride &amp; fluticasone propionate) nasal spray</b>	
_____	137/50mcg Nasal Spray 23g
QTY _____	
<b>EMSAM® Transdermal System</b>	
_____	12 mg/24 hr Bx30
QTY _____	
_____	6 mg/24 hr Bx30
QTY _____	
_____	TDS 9 mg/24 hr Bx30
QTY _____	
<b>ERMEZA™ (levothyroxine sodium) oral solution</b>	
_____	150 mcg/5mL 150mL
QTY _____	
_____	150 mcg/5mL 75mL
QTY _____	
<b>Felbatol® (felbamate)</b>	
_____	400mg T 100s
QTY _____	
_____	600mg T 100s
QTY _____	
<b>Gastrocrom® (cromolyn sodium, USP) oral concentrate</b>	
_____	100mg 5mL Oral Concentrate 96s
QTY _____	
<b>Perforomist® (formoterol fumarate) Inhalation Solution</b>	
_____	20 mcg / 2 mL 30x1
QTY _____	
_____	20 mcg / 2 mL 60x1
QTY _____	

<b>Pretomanid Tablets</b>	
_____	200mg T 26
QTY _____	
<b>Proctofoam® HC (hydrocortisone acetate 1% and pramoxine hydrochloride 1%)</b>	
_____	HC 1% 10g
QTY _____	
<b>ROWASA® (mesalamine) Rectal Suspension</b>	
_____	60mL Rectal Susp 7s
QTY _____	
_____	60mL Rectal Susp 28s
QTY _____	
<b>sfROWASA® (mesalamine) Rectal Suspension</b>	
_____	60mL Rectal Susp 7s
QTY _____	
_____	60mL Rectal Susp 28s
QTY _____	
<b>TYRVAYA® (varenicline solution) nasal spray</b>	
_____	0.03 mg 2pk
QTY _____	
<b>Wixela Inhub® (fluticasone propionate and salmeterol inhalation powder, USP)</b>	
_____	100mcg/50mcg 60/Inh
QTY _____	
_____	250mcg/50mcg 60/Inh
QTY _____	
_____	500mcg/50mcg 60/Inh
QTY _____	
<b>XULANE® (norelgestromin and ethinyl estradiol transdermal system)</b>	
_____	TDS 0.15mg/0.035mg/QD 3s
QTY _____	
<b>Yupelri® (revefenacin) inhalation solution</b>	
_____	175mcg / 3mL 30s
QTY _____	



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**Prescription Details- Please complete all relevant prescription details below**

Patient Name: \_\_\_\_\_ Patient DOB: \_\_\_\_\_

Prescriber Name: \_\_\_\_\_ Prescriber NPI: \_\_\_\_\_

Day Supply: \_\_\_\_\_ Refills: \_\_\_\_\_

Directions: \_\_\_\_\_

**Prescriber Certification and Prescription Signature**

I certify that the information provided in this Patient Assistance Program Application is complete and accurate to the best of my knowledge, that the Viатris product I have prescribed to the applicant within this application is based on my professional judgment of medical necessity for a Food and Drug Administration (FDA) approved indication, and that I will supervise the patient's medical treatment. I will notify Viатris PAP immediately if the Viатris product is no longer medically necessary for this patient's treatment. I certify that I have obtained from my patient all required written authorizations for the release of my patient's personal identification and insurance information to Viатris and their agents and representatives.

By signing below, I attest that I can prescribe, receive, store, and dispense the Viатris product and that I, and the facility located at the shipping address I provided above that will receive the product, hold all required state licenses to receive, store, and dispense the product.

I understand that any information provided to Viатris and its agents and representatives is for the sole use of Viатris and their agents, service providers, and representatives to verify my patient's insurance coverage status, to assess the patient's eligibility for participation in the Viатris Patient Assistance Program (collectively, "the Program"), and to otherwise administer the product and related services. I understand that application to the Program does not guarantee that assistance will be obtained.

I understand that Viатris may change or cancel this program at any time. I understand that if my patient's financial and/or insurance status changes, the patient may no longer be eligible for the Program, and I agree to immediately notify a Viатris PAP representative if I become aware of changes in the patient's financial and/or insurance status. I agree that Viатris PAP may contact me for additional information relating to this application either by fax, e-mail and/or telephone. I understand that I am under no obligation to prescribe any Viатris product and that I have not received, nor will I receive, any benefit from Viатris or its agents or representatives for prescribing a Viатris product. I agree that I will not sell, submit claims or make any attempt to receive reimbursement from any third party for any product provided by the Program.

By signing this Patient Assistance Program Application, I authorize the release of medical and/or other patient information to agents and service providers of Viатris to use and disclose as necessary for verification of patient eligibility, and to furnish any information on this form to the insurer of the applicant for the purpose of verifying benefit eligibility. I understand that Program duration per eligibility period is 12 months, and the maximum number of refills per eligible patient is 11 for each unique enrollment.

**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 Viатris, its affiliated companies, vendors, agents, collaboration partners, and representatives (together, "Viатris") including providers of alternate sources of funding for prescription drug costs, and other service providers supporting the Viатris 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 Viатris, I understand that federal privacy laws no longer protect the information. However, Viатris 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 Viатris Patient Assistance Program and the services provided by Viатris 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 3711 Collins Ferry Road Morgantown, WV 26505, 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 Viатris, I will receive my Prescribed Product from Viатris 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, Viатris 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 Viатris 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 Viатris 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 Viатris under the Fair Credit Reporting Act authorizing Experian on behalf of Viатris to obtain information from my credit profile or other information from Experian. I authorize Viатris 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.

Viатris, Inc. and its affiliates and subsidiaries process your personal data (Name, Contact information, DOB, Social Security number, Gender, Insurance Status, and income) in order to determine whether you qualify for enrollment in the patient assistance program and, if you are enrolled, to administer your participation in the program. You may have the right to report concerns to the authority responsible for data protection where you live or work. You can learn more about our data protection practices in our Viатris Privacy Notice at <https://www.viatris.com/en/viatris-privacy-notice>, you can learn about the personal data we process, how it is shared, where it is stored, to where it may be transferred, for how long we keep it, and how to contact our Data Protection Officer. For questions or concerns related to data protection, please email [dataprivacy@viatris.com](mailto:dataprivacy@viatris.com).

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

**Patient Name (Print):** \_\_\_\_\_ **Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



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## Patient Authorized Representative

I permit Viatis PAP Support Services representatives to speak with the following person about this application form. This includes discussing the status of my application, insurance and financial questions, any missing documentation and other issues related to my enrollment, or any other treatment-related issues. I may cancel this Patient Authorized Representative Authorization at any 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 behalf on any matter regarding my enrollment with the Program.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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