Viatris Patient Assistance Program (PAP) Application

| Phone: 888-417-5782 | Fax: 866-792-7945 | M-F, 8AM to 5PM CST |

Please complete application in full, sign and date, then fax to: 866-792-7945

Or email to: ViatrisPAP@Cardinalhealth.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:
  - Applicants qualify for the program financial requirements.
  - Applicants must be a current United States resident *(includes U.S Territories)*.
  - Applicants must be fully Uninsured*.
    - *Underinsured applicants requesting Ogivri or Fulphila may apply.
  - 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 Demographic Information

Reset Patient Info

Name: _____ (First / Last) Date of Birth: ___/___/___ (Mo / Day / Year) SSN: _____

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: _____ Insurance Phone:

Prescriber Information

Reset HCP Info

Prescriber Name: _____ Prescriber NPI: _____

Facility Name: _____ State License #: _____ SL# Expiration: _____

Facility Address: _____ City: _____ State: ZIP: _____

Primary Office Contact: _____ Fax Number: _____

Phone Number: _____ Office Contact Email: _____

Prescriber Shipping Information *(Only complete if shipping address is different than address listed above)*

Reset Shipping Info

Prescriber Name: _____ Facility Name: _____

Shipping Address: _____ City: _____ State: ZIP: _____

Shipment Contact Name: _____ Shipping Fax Number: _____

Shipping Phone Number: _____ Contact Email: _____

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Product & Prescription Information *(Select a Product and complete Rx Details below)*

Reset Product & Rx Info

Enter the quantity (QTY) needed for a single product strength and package size selection below

Caduet® (amlodipine besylate, atorvastatin calcium)

- ___ QTY 10/10mg FCT 1x30 BTL US
- ___ QTY 10/20mg FCT 1x30 BTL US
- ___ QTY 10/40mg FCT 1x30 BTL US
- ___ QTY 10/80mg FCT 1x30 BTL US
- ___ QTY 5/10mg FCT 1x30 BTL US
- ___ QTY 5/20mg FCT 1x30 BTL US
- ___ QTY 5/40mg FCT 1x30 BTL US
- ___ QTY 5/80mg FCT 1x30 BTL US

Inspra® (eplerenone)

- ___ QTY 25mg TAB 1x30 BTL US
- ___ QTY 25mg TAB 1x90 BTL US
- ___ QTY 50mg TAB 1x30 BTL US
- ___ QTY 50mg TAB 1x90 BTL US

Relpax® (eletriptan HBr)

- ___ QTY 20mg TAB 1X6 BLST US
- ___ QTY 40mg TAB 1X6 BLST US
- ___ QTY 40mg TAB 2X6 BLST US

Fulphila® (pegfilgrastim-jmdb)

- ___ QTY 6mg/0.6mL PFS 1PK

Detrol® (tolterodine)

- ___ QTY 1mg TAB 1x60 BTL US
- ___ QTY 2mg TAB 1x60 BTL US

Glatiramer Acetate (Injection)

- ___ QTY 20mg/mL 1x30 BOX
- ___ QTY 40mg/mL 1x12 BOX

Ogivri® (trastuzumab-dkst)

- ___ QTY 150mg Single Dose Vial
- ___ QTY 420mg LYO Kit 1PK

EpiPen® (epinephrine injection)

- ___ QTY 0.3 mg, 2-Pak w/trainer

Detrol® LA (tolterodine tartrate)

- ___ QTY 2mg CAP 1x30 BTL US
- ___ QTY 4mg CAP 1x30 BTL US
- ___ QTY 4mg CAP 1x90 BTL US

Tobi® (tobramycin)

- ___ QTY 300mg/5mL 56s (ampules)
- ___ QTY 28mg 4(7x8) (podhaler) 224

EpiPen Jr® (epinephrine injection)

- ___ QTY 0.15 mg, 2-Pak w/trainer

Prescription Details- *Please complete prescription details below*

Patient Name: _____ Patient DOB: ___/___/___ (Mo / Day / Year)

Prescriber Name: _____ Prescriber NPI: _____

Day Supply: _____ *(Up to 90-day supply)* Refills: _____ Directions: _____

Current Medications: _____

Allergies: _____

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 Viatris 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 Viatris PAP immediately if the Viatris 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 Viatris and their agents and representatives.

I understand that any information provided is for the sole use of Viatris 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 Viatris 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 Viatris 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 Viatris PAP representative if I become aware of changes in the patient's financial and/or insurance status. I agree that Viatris 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 Viatris product and that I have not received, nor will I receive any benefit from Viatris or their agents or representatives for prescribing a Viatris product. I agree that I will not sell, submit claims to, or make any attempt to receive reimbursement from any 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 Viatris (including but not limited to Sonexus Health LLC and the dispensing non-commercial pharmacies) 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. 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 (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 Healthcare Providers and patients 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,
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 or receive assistance from the Program.

I understand that my signed Authorization is valid for 5 years from date of 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 2730 S. Edmonds Lane, Suite 300 Lewisville, TX 75067, fax to 866-792-7945, or by calling 888-417-5782. 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 888-417-5782 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 and its vendor Sonexus Health, LLC under the Fair Credit Reporting Act and authorizing Sonexus Health, LLC on behalf of Viatris to obtain information from my credit profile or other information from Experian Health. I authorize Viatris and its service provider Sonexus Health 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 Representative

I permit Viatris 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: 888-417-5782

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:** _____