# Sancuso (Granisetron Transdermal System)
# Patient Assistance Program

The Sancuso Patient Assistance Program provides Sancuso at no cost to eligible patients experiencing financial difficulties. Eligible patients typically have no healthcare coverage for the requested product and do not have access to alternative sources of coverage or funding.

All applications are reviewed on a case-by-case basis to support the Sancuso Patient Assistance Program's purpose of providing products at no cost to eligible individuals (please see eligibility criteria at www.patientrxsolutions.com).

## Checklist for submitting an application:

- Ensure all sections of the application are completed. Make a copy before sending, as no documents will be returned.
- Attach current proof of income (tax return, W2, pay stub) for all in household.
- Patient's signature/date is required on the application.
- Prescriber's signature/date is required on the application.
- Provide a copy of Medicare card or letter of Medicaid and/or Social Security denial, if applicable.

## Fax or mail the completed application and documentation to:

Patient Rx Solutions
Sancuso Patient Assistance Program
PO Box 325
Florham Park, NJ 07932
Phone: 866-325-8231
Fax: 866-694-2546

Upon receipt of a completed application, the prescriber and patient will be notified of program eligibility. If the patient is eligible for assistance, a supply of medication will be shipped to the prescriber's office. It is the responsibility of the prescriber or office staff to reorder 3 weeks prior to the patient requiring further medication.

Please contact us at 866-325-8231 Mon-Fri 9am-5pm Eastern Time for additional assistance.

patient Rx solutions PatientAssistance

KYOWA KIRIN

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## Patient Information

Patient Name _____ Gender ☐ Male ☐ Female Telephone Number _____

Patient Address _____ City _____ State _____ Zip _____

Date of Birth _____ SSN (Last four digits only) _____

Are you enrolled in Medicare? ☐ Yes ☐ No If YES, check all that apply: ☐ Part A ☐ Part B ☐ Part D

Do you have private insurance coverage for prescriptions? ☐ Yes ☐ No Are you covered through a state Medicaid Program? ☐ Yes ☐ No

Total Monthly Income for your entire household $ _____

**Attach the most current copies of income documentation for you and all dependent persons. Acceptable documents include: Federal Tax Return, SSA 1099, W2, pay stubs or benefits award letter.**

I understand that any assistance in the form of product at no cost is contingent upon my ability to meet the eligibility criteria for the Sancuso Patient Assistance Program. In the event that I am eligible for Program assistance, I acknowledge that this assistance is temporary and that I may be asked to reapply at designated intervals by the Program. I also understand that the Program assistance may change or be discontinued at any time without any notice to me. I agree that I will not seek reimbursement for any products dispensed under the Program from any government program or third party insurer. I certify that the information I have provided in this form is accurate and complete. I understand that by completing this form I am not guaranteed eligibility to receive medication from the Program. I agree that I will notify the Program if my insurance or financial situation changes. The Program will use my information for purposes of determining patient assistance eligibility. I understand that I need to give my authorization to take part in the Program's Patient Assistance Program ("PAP") (should I qualify). I know I may cancel this authorization at any time by writing to the Sancuso Patient Assistance Program at P.O. Box 325 Florham Park, NJ 07932. If I cancel this Authorization, I can no longer participate in the PAP. This authorization shall be valid for 5 years from the date of the signature on this form. I authorize the Program to use my information: (i) to determine eligibility for the PAP, (ii) to account for my withdrawal if I decide to stop participating in the PAP, (iii) to administer and maintain high quality service, and (iv) as otherwise required or permitted by law. I agree that the Program does not have any liability in providing PAP services to me.

**Patient's Signature** _____ **Date** _____

Number of people in your household (including yourself): _____ Number in household under 18: _____

## Representative For Purposes of Program (If applicable)

I permit the Sancuso Patient Assistance Program to speak with the following person(s) about my application and/or care and sign any documents related to the Program on my behalf:

Name _____ Relationship _____ Telephone Number _____

## Personal Representative Authorization (If applicable)

Note: If the Applicant is unable to sign, is under the age of 18, or has designated signature authority, the Applicant's Personal Representative may sign this Form. However, only certain individuals may qualify as the Applicant's Personal Representative for purposes of this Authorization. An Applicant's Representative must have the requisite knowledge and information regarding the Applicant's financial and health care status to verify that all responses provided are accurate. State law may prescribe who can be a Personal Representative for purposes of this Authorization. A person or entity in the supply chain of the product to be received through the Program, including a health care provider or pharmacy receiving the medicines at no cost, may not be named a Personal Representative. If Applicant's Personal Representative is a consumer assistance or charitable organization, please list name of entity and purpose of entity under Relationship to Applicant.

Patient's Representative Signature _____ Relationship _____ Date _____

## Prescription Information

Medication/Strength _____ Directions Use as directed Quantity _____ Signature _____ Reorders allowed: up to 1 year

## Prescriber Information

Prescriber Name _____ Professional Designation of Prescriber _____ State License Number (SLN) _____ SLN State _____ SLN Expiration Date _____

Shipping Address _____ City _____ State _____ Zip _____

Mailing Address _____ ☐ Check here if same as shipping address City _____ State _____ Zip _____

Office Contact Person _____ Telephone Number _____ Fax Number _____

1. Authorization for Release of Protected Health Information (PHI): By signing this form, I represent to the Sancuso Patient Assistance Program that I have obtained all necessary Federal and state authorizations and consents from my patient to allow me to release PHI to the Sancuso Patient Assistance Program and its contracted third parties.
2. Prescriber: I verify that the information provided is current, complete and accurate to the best of my knowledge and certify that I am authorized to receive medications at the shipping location identified in this application. I verify that my State License is currently in good standing. I further certify that I will notify the Sancuso Patient Assistance Program (the "Program") in writing immediately if the status of my State License Number registration changes. If this applicant is eligible for the Sancuso Patient Assistance Program assistance, I understand that the Program will send the medication to my office for dispensing to the patient. The Program reserves the right to request additional information if needed and to change or discontinue the assistance at any time, without notice. By signing this form, I certify that I am prescribing the aforementioned medication for an individual participating in the Program. I acknowledge that I shall not seek reimbursement for any medication dispensed hereunder from any government program or third party insurer. I also understand that the applicant's acceptance by the Sancuso Patient Assistance Program is not made in exchange for any explicit or implicit agreement or understanding that Kyowa Kirin Product will be used, purchased, leased, ordered, prescribed, recommended, or arranged for or provided formulary or other preferential or qualifying status. I understand that I may not delegate signature authority. I certify that treatment with this medication is medically necessary.

**Prescriber's Signature** _____ **Date** _____

**Notice to Health Care Providers and Insurers:** This form of authorization may not comply with all applicable Federal and state laws governing disclosure of the applicant's information to the Program and its contracted third parties. The Program urges all entities disclosing information about the applicant to consult with legal counsel prior to relying on this form.

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## Authorization For Disclosure Of Information

I, _____, authorize my prescriber(s), my health plan or insurers, and any other healthcare providers to give to Asembia, the Program Administrator, and/or any other affiliated companies, subcontractors, vendors, and/or partners (collectively "Program Administrator") health information that helps with my enrollment into, and for proper administration in determining coverage for the prescribed Kyowa Kirin product under my current health insurance plan.

This information may include spoken or written facts about my medical condition, my health insurance benefits, name, date of birth, address, telephone number(s), social security number, and/or financial information. It may include copies of records from my healthcare providers or health plans outlining my medical history and my treatments. All of this information may be considered protected health information (PHI) as governed and protected by the Health Insurance Portability and Accountability Act (HIPAA) of 1996 as amended and under the rules and regulations there under.

I authorize Program Administrator and Asembia to use and/or disclose my PHI for the following purposes:

- Determine whether my health insurance benefits will pay for Program Administrator's product
- Locate a specialty pharmacy for me that can fill my prescription, if applicable, and facilitate dispensing of my prescription by sending my information to that specialty pharmacy
- Determine my eligibility for participation in or to help find other ways to pay for those products, and for proper management and administration of the program
- Provide free information and patient educational materials to me about my condition, treatment options, products, and/or program offerings
- Provide me with information about compliance with treatments my healthcare provider has prescribed

I know that people who work for and with its sponsor, Program Administrator, may use and receive my information, but they may use it only as authorized in this form or for such purposes as may be required by applicable law. I understand that Program Administrator will keep my information private and use and disclose it only as allowed on this form. I understand that, once it is disclosed, it may be further disclosed by the recipient(s) and federal privacy laws will not protect it if the entities receiving the information are not subject to those laws.

This authorization will last for five years after the date I sign this form. If I change my mind before that time and want to stop participating in the program, I can tell Program Administrator by writing to the address on this form that I want to cancel this authorization. I understand that I cannot cancel any actions that have already been taken by relying on this authorization.

I know that I may refuse to sign this form. My choice about whether to sign this form will not change the way my healthcare providers treat me. However, I understand that my refusal to sign this form may not allow me to participate in this program. I understand that Program Administrator does not promise to find ways to pay for my medication(s) and I know that I am responsible for the costs of my care. I agree that a copy of this form may be treated as a signed original.

Patient Signature: _____ Date: _____
If the patient cannot sign, the patient's representative must sign below

Patient Representative Signature: _____ Date: _____
(Signature of person signing for patient)

Describe relationship to patient and right to act for patient _____

Provide a copy of this form to the patient/patient's representative.

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