ARBOR PHARMACEUTICALS PATIENT ASSISTANCE PROGRAM

P.O. Box 6123, Lawrenceville, NJ 08648 Telephone: (844) 884-8700 / Fax: (844) 287-5417

PATIENT ASSISTANCE PROGRAM

Dear Applicant,

Thank you for your interest in the Arbor Pharmaceuticals, LLC. Patient Assistance Program (PAP). Enclosed you will find the requested application. It is important that you complete all requested information and sign where indicated. Incomplete or incorrect applications will delay the application process.

Please Note: If the prescription changes, a new application must be submitted for approval.

PATIENT REQUIREMENTS:

- Complete all fields in Sections 1.1 & 1.2 on Page 1 of the Application.
- Complete Certification Sections 3.1 & 3.2 *(if applicable)* on Page 2 of the Application.
- **Attach** a copy of the ANNUAL household income (Federal tax return (1040), social security income (SSA 1099), pensions, interest, retirement, child support, etc.). See income requirements on the next page.
- **Attach** a photocopy of your LIS Denial Letter (for Medicare Part D plan applicants only).
  If you are a Medicare Part D enrollee you must have applied for and been denied the Low Income Subsidy (LIS) from the Social Security Administration. In order to apply for LIS, please contact the SSA at (800) 772-1213 or go to www.socialsecurity.gov/prescriptionhelp/.
- **Attach** a photocopy of your Medicaid Denial *(if applicable)*.
  If you have applied for Medicaid in the past and been denied, please attach a copy of Medicaid denial.

LICENSED PRACTITIONER REQUIREMENTS:

- Complete all fields in Sections 2.1 & 2.2 on Page 1 of the Application.
- Complete Certification Section 4.1 on Page 2 of the Application.
- **Attach** a photocopy of the prescription written for medication listed in section 2.2.
  Note: If the preprinted office address on the prescription does not match the delivery/mailing address provided in Section 2.1 on the Arbor Pharmaceuticals, LLC. PAP Application form, then the licensed practitioner must attach a copy of their letterhead or a business card to verify the delivery/mailing address provided in Section 2.1.

MAIL COMPLETED APPLICATION TO:
Arbor Pharmaceuticals, LLC.
Patient Assistance Program
PO BOX 6123
LAWRENCEVILLE, NJ 08648

OR FAX TO:
(844) 287-5417

APPLICATION PROCESSING:

Please allow 4 weeks for application processing and delivery of medication to the licensed practitioner named on the application form. If the application is approved the medication requested will be shipped directly to the licensed practitioner's office for dispensing.

- Chronic care patients will receive a 3-month supply every 3 months, not to exceed one year.
  - Prescriptions for chronic care patients must be written for one year.
  - A new application will need to be submitted for approval after the 1-year enrollment period.
- Acute care patients will receive a one-time shipment and must reapply for each subsequent prescription.
- Please note missing HCP and/or Patient signature on the application will delay processing.

Upon approval, the applicant will be notified by mail. If the applicant is denied, the licensed practitioner and the applicant will be notified by mail. If the application is incomplete the applicant will be notified with instructions for completion.

If you have questions or need further assistance, please call our Patient Advocacy Center at 1-844-884-8700 between 8:30 AM and 7:00 PM EST, Monday through Friday.

Sincerely,
Arbor Pharmaceuticals, LLC.
Patient Assistance Program

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ELIGIBILITY REQUIREMENTS

Eligibility is based on the following requirements:

- You must not be covered by any private, public, or Medicare Part D health insurance and prescription coverage programs.
- You must be a citizen of the United States.
- You must be an outpatient currently under the care of a physician.

2018 FEDERAL POVERTY GUIDELINES

Household Income Requirement: Patient must not have a household income that exceeds 300% of the current US Federal Poverty Guideline for Bidil, and 200% for all other products:

Household Size	200% of FPL			300% of FPL (Bidil)		
Persons in Family or Household	48 Contiguous States and D.C.	Alaska	Hawaii	48 Contiguous States and D.C.	Alaska	Hawaii
1	$24,280	$30,360	$27,920	$36,420	$45,540	$41,880
2	$32,920	$41,160	$37,860	$49,380	$61,740	$56,790
3	$41,560	$51,960	$47,800	$62,340	$77,940	$71,700
4	$50,200	$62,760	$57,740	$75,300	$94,140	$86,610
5	$58,840	$73,560	$67,680	$88,260	$110,340	$101,520
6	$67,480	$84,360	$77,620	$101,220	$126,540	$116,430
7	$76,120	$95,160	$87,560	$114,180	$142,740	$131,340
8	$84,760	$105,960	$97,500	$127,140	$158,940	$146,250

Note: Household Size of 9+ will be based on the Household Size of 8.

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APPLICATION

SECTION 1.1: PATIENT INFORMATION

First Name (legal)	MI	Last Name	Gender: (circle one) M F
Phone Number	Social Security Number		Date of Birth
Mailing Address			Apt Number
City	State		Zip Code
Marital Status	Email Address		

Gross Monthly HOUSEHOLD Income:_____ Number of People in Household (include yourself):_____

☐ By checking this box and signing sections 3.1 and 4.1 below, I attest to the veracity of the claim of zero income.

Have you attached a photocopy of your annual household income (Federal tax return (1040), social security income (SSA 1099), pensions, interest, retirement, child support, etc.)? ☐ Yes ☐ No

Do you have prescription coverage/reimbursement at any time during the year? ☐ Yes ☐ No

If yes, please provide your carrier's name & benefits received for the requested medication:_____

SECTION 1.2: MEDICARE/MEDICAID INFORMATION

Are you enrolled in Medicare? ☐ Yes ☐ No Are you enrolled in Medicaid? ☐ Yes ☐ No

Medicare ID#:_____ Are you enrolled in Medicare Part D plan? ☐ Yes ☐ No

*Medicare Part D enrollees: you must have applied for and been denied the Low Income Subsidy (LIS) from the Social Security Administration before submitting this application. In order to apply for LIS, you may contact the Social Security Administration at (800) 772-1213, or visit www.socialsecurity.gov/prescriptionhelp/.

Please attach a photocopy of your LIS denial letter to this application.

Have you attached a copy of your Medicare Part D LIS Denial Letter? ☐ Yes ☐ No

SECTION 2.1: LICENSED PRACTITIONER INFORMATION (To be completed by the patient's licensed practitioner)

First Name (legal)	MI	Last Name		Professional Designation
State License Number		DEA Number		
Mailing Address		City	State	Zip Code
Delivery Address		City	State	Zip Code
Office Contact Name		Phone Number		Ext.
Office Contact Email Address				

SECTION 2.2: PRESCRIPTION INFORMATION (To be completed by the patient's licensed practitioner)

Medication:_____ Dosage:_____

This medication is being prescribed for ☐ Acute Care ☐ Chronic Care

* Attach a copy of the prescription to this application.*

BOTH PATIENT AND LICENSED PRACTITIONER MUST SIGN AND DATE THE CERTIFICATIONS ON PAGE 2 OF THIS APPLICATION.

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CERTIFICATIONS

SECTION 3.1: PATIENT CERTIFICATION

I certify that I do not have the ability to pay for the medication requested by my licensed practitioner in section 2.2 of this application and all information provided in section 1.1 and 1.2 is correct. I understand that Arbor Pharmaceuticals, LLC. Patient Assistance Program is entitled to request additional verification of any such information at any time, which I agree to provide. I consent that Arbor may contact me for verification of my application status and receipt of the indicated medications. I understand that if approved, I am not eligible to seek reimbursement for any medication requested in section 2.2 of this application from any government program or third party insurer. I understand eligibility under the Arbor Pharmaceuticals, LLC. PAP is subject to Arbor's discretion and that Arbor reserves the right to modify or terminate the PAP at any time. I authorize my physician to provide Protected Health Information ("PHI") (as such term is defined in the Health Insurance Portability and Accountability Act and regulations there under, "HIPAA", as well as other state or federally protected personal information), to Arbor or third parties engaged, as required to assist Arbor in administering the PAP. I authorize Arbor to disclose my PHI to Centers for Medicare and Medicaid Services ("CMS") for the purpose of verifying my Medicare Part D enrollment status and disclosing my enrollment in Arbor Pharmaceuticals, LLC. PAP with my Medicare Part D plan. I understand that my PHI will consist of my name, address, social security number, income, prescription coverage, prescription for medication, financial documents and insurance records and will be used for purposes of determining my eligibility to participate in the Arbor PAP and to ship appropriate medication(s) as prescribed by my licensed practitioner. I further understand that if my PHI is incomplete or completed PHI does not allow me to participate in Arbor's PAP that I may be notified of such by Arbor. I understand that upon the furnishing of my PHI to Arbor, my PHI may not be subject to all of the protections and safeguards provided by HIPAA or other federal and state privacy laws. This authorization will extend for as long as I participate in the PAP and will thereafter expire. I may revoke this authorization at any time by providing written notice to Arbor at the address set forth above. My revocation will become effective on the date my written notice is received and processed at Arbor Pharmaceuticals, LLC. PAP.

Patient or Legal Guardian's ORIGINAL Signature: **Date:**

_____

SECTION 3.2: MEDICARE PART D ENROLLEE CERTIFICATION *(if applicable)*

I understand that if I am approved for Arbor Pharmaceuticals, LLC. PAP, I will receive a three-month supply of medication and that I must re-apply to Arbor Pharmaceuticals, LLC. PAP each time I need medication. I understand that if my application continues to meet the guidelines of Arbor Pharmaceuticals, LLC. PAP, I will continue to be approved to receive subsequent three-month supplies of medication up to 12 months for Chronic Care prescriptions and a one-time shipment for Acute Care prescriptions. I will reapply for each subsequent Acute Care request as needed. I agree that I will not seek the requested Arbor medication from my Medicare Part D prescription plan while receiving the medication from Arbor PAP. I understand that I am not eligible to seek reimbursement for any medication dispensed by Arbor from any government program or third party insurer and will not apply any Arbor Pharmaceuticals, LLC. PAP medication towards True Out-Of-Pocket ("TrOOP") costs.

Patient or Legal Guardian's ORIGINAL Signature: **Date:**

_____

SECTION 4.1: LICENSED PRACTITIONER CERTIFICATION

My signature certifies that I am a licensed practitioner eligible under state law, my collaborative agreement and formulary, if applicable, to prescribe, receive and dispense the requested medication(s) listed on this application, provided by Arbor Pharmaceuticals, LLC. I further certify all information provided in section 2.1 & 2.2 is correct and agree to submit appropriate verification of such information upon Arbor's reasonable request. I agree that medication(s) provided to me by Arbor pursuant to prescriptions provided by me for the applicant named in 1.1 will be provided by me to such eligible applicant for his or her own use without charge. I will not otherwise use any of such medications or prescribe, provide or dispense all or any portion thereof for the use of any other person. I consent that Arbor may contact the applicant named in section 1.1 for verification of applicant status and receipt of the indicated medication(s). I further consent that Arbor may perform an on-site audit of PAP records related to the applicant named in 1.1 of this application. I understand that I am not eligible to seek reimbursement for any medication dispensed by Arbor Pharmaceuticals, LLC. PAP from any government program or third party insurer and will not apply any Arbor PAP medication towards the applicant's TrOOP. I further understand that I cannot seek payment for an office visit from the applicant or third party insurer when Arbor PAP medication is provided to the applicant. I also understand that eligibility under the PAP is subject to Arbor Pharmaceuticals, LLC.'s discretion and that Arbor Pharmaceuticals, LLC. reserves the right to modify or terminate the PAP at any time.

Physician's ORIGINAL Signature: Must be Original Signature – No stamped Signatures Accepted **Date:**

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