MERZ CONNECT™

Contact the MERZ CONNECT™ Support Line
1-855-4MERZTX (1-855-463-7989), option 4
Monday – Friday 8am – 7pm ET
Fax 1-855-825-0488

XEOMIN® incobotulinumtoxinA

PATIENT ASSISTANCE PROGRAM (PAP) FORM

1. PATIENT INFORMATION

Patient First Name _____ Patient Last Name _____ MI ____

Date of Birth (MM/DD/YYYY) _____ Gender ☐ M ☐ F

Street Address _____ City _____ State _____ Zip _____

Preferred phone # _____

Legal Guardian Name _____ Relationship to Patient _____

Legal Guardian Phone _____ Patient/Legal Guardian Email *(Required)* _____

2. INSURANCE INFORMATION *(Please attach a copy of the front and back of the patient's insurance card)*

☐ **UNINSURED** Patient does not have commercial health insurance, and is not eligible for public health insurance, including but not limited to Medicare or Medicaid, or has been denied coverage by their health insurance.

☐ **UNDERINSURED** Patient with commercial insurance where XEOMIN is not adequately covered and patient meets program eligibility requirements.

PRIMARY Insurance Name _____ Phone Number _____

Policy holder _____ Policy holder ID # _____ Group ID # _____

Policy holder Date of Birth (MM/DD/YYYY) _____ Policy holder's Relationship to Patient _____

SECONDARY Insurance Name _____ Phone Number _____

Policy holder _____ Policy holder ID# _____ Group ID# _____

Policy holder Date of Birth (MM/DD/YYYY) _____ Policy holder's Relationship to Patient _____

3. PROOF OF INCOME*

My estimated annual household income currently is $_____ Number of people in household _____

I agree that I may be asked to provide proof of income for eligibility and to provide such proof of income upon request.

**Examples of income can include, but not limited, to Social Security Disability, Supplemental Security income, Aid from the Department of Public Welfare, Unemployment Benefits, Workers Compensation Benefits, Dividends, interest or investment account, Employment (myself and/or mspouse or caregiver if I am a dependent), Other (includes assistance from friends, family, charity or church)*

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4. PATIENT CERTIFICATION *(To be completed by Patient/Legal Guardian)*

By signing below, I (Patient/Legal Guardian) certify the following:

- The information on this form is correct and complete, including all copies of documents proving income. Merz Pharmaceuticals, LLC, its affiliates and/or its third party agents (collectively, "Merz") may use this information to determine eligibility to participate in the XEOMIN Patient Assistance Program (the "Program") including, without limitation, The Lash Group, LLC ("Administrator").
- I certify that I/patient cannot afford this medication. I understand that assistance received through the Program is not insurance.
- I understand that if the information is incomplete or the completed information does not allow participation in the Program, that I or my above-named healthcare provider may be notified of such by Merz or the Administrator.
- I also understand that the Program may obtain credit reports or investigative credit reports about me/patient which may contain information as to my/patient's income or credit standing, to estimate my/patient's income, in order to determine eligibility for the Program. Consistent with the federal Fair Credit Reporting Act and any other applicable law, I hereby affirmatively agree and authorize such credit report and income verification and acknowledge that such authorization extends to consumer reporting agencies and to subsequent reports to estimate my/patient's income, for purposes of determining my/patient's eligibility for the Program. I understand that, upon request, the Program will inform me whether such a report was requested and the name and address of the agency that furnished it.
- I am not/Patient is not currently receiving any benefits or coverage for XEOMIN from Medicaid, Medicare, or any other public or private insurance company or assistance program. I acknowledge and agree that I shall not report or count the value of any product provided to me/Patient through the Program toward any insurance deductible or, if I am/Patient is enrolled in Medicare Part D, as true out-of-pocket spending (TrOOP) under my/Patient's Medicare Part D prescription drug benefit.
- I/Patient will not seek reimbursement from any insurance provider or plan, including any Medicare Part B or Medicare Part D plan, for the cost of any free product provided through the Program, and for the remainder of my/Patient's eligibility period I/Patient will continue to receive all my/Patient's prescriptions for XEOMIN through the Program.
- I/Patient will notify the Program within thirty (30) days if there is any change in the status of my/Patient eligibility related to changes in income or health coverage to receive products through the Program. This includes a change in my/Patient's eligibility to participate in the Medicare program due to change in age or disability status or enrollment in Medicare Part D or in any other Governmental health care program.
- I understand that the Program does not cover any provider administration fee. If my/Patient's provider is not able or willing to waive this fee for administering XEOMIN, then this fee is my/legal guardian responsibility.
- I understand that this form expires in one year or when my/Patient's Program eligibility expires.
- The Program may be modified or discontinued at any time, without further notice.
- I authorize the above-named physician and any associated health care provider or staff to submit this Application on my/Patient's behalf.
- I understand that signing this authorization does not guarantee that I/Patient will be accepted into the Program.

Patient Name (Print) Date

Patient/Legal Guardian Signature *(If the Patient cannot sign, the Patient's personal representative must sign below)*

Patient Representative or Legal Guardian Name (Print) Patient Representative or Legal Guardian Signature

Relationship to the Patient, and authority to make medical decisions for Patient

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Patient First Name _____ Last Name _____ Date of Birth (MM/DD/YYYY) _____

5. HEALTHCARE PROVIDER INFORMATION & DIRECT SHIPPING INFORMATION

Healthcare Provider Name _____ Email _____
Facility Name _____
Street Address _____ City _____ State _____ Zip _____
Phone # _____ Ext # _____ Secure Fax # _____
Office Contact Name _____ Office Contact Phone # _____
National Provider Identification # _____ State License # _____ Medicare Provider # _____
Blue Cross Provider # _____ Group Tax ID # _____
May we contact your patient? ☐ Yes ☐ No
Place of Service Name *(if different from above)* _____ Address _____

6. TREATMENT/PRESCRIBING INFORMATION *(To be completed by the Healthcare Provider)*

Site of Service : ☒ Physician Office ☐ ASC: Hospital Outpatient ☐ ASC: Hospital Inpatient

Drug Name _____ Total Patient Dosage: _____

Number of Vials ☐ .50 Unit _____ ☐ 100 Unit _____ ☒ 200 Unit _____

Treatment Date *(if known)* (MM/DD/YYYY) _____ Number of refills _____

Healthcare Provider Signature *(No stamp)* _____ Date _____

HEALTHCARE PROVIDER CERTIFICATION *(To be completed by treating physician)*

By signing below, I certify the following:

- I will be supervising the above-named Patient's treatments.
- To the best of my knowledge, this Patient does not have prescription drug insurance coverage; including Medicare, Medicaid, state pharmaceutical assistance program, county funded, Veterans, or other public programs) for XEOMIN.
- I am not prohibited from participating in Federally-funded health care programs nor am I on the List of Excluded Individuals/ Entities maintained by the HHS Office of Inspector General.
- Any product received from or on behalf of Merz Pharmaceuticals, LLC, or its affiliates ("Merz") in connection with the XEOMIN Patient Assistance Program (the "Program") will used only for the Patient. Any units not used to treat the patient are considered biomedical wastage and will be disposed.
- Neither I nor my practice shall
  - » Charge the Patient any fee for enrollment or other activities associated solely with the Patient's participation in the Program,
  - » Charge the Patient for those professional services associated with the Program not covered by the Patient's health insurer,
  - » Bill, make any claim to, or collect from any third-party payer (e.g., Medicaid, Medicare, public or private insurance, etc.) concerning any product received from Merz in connection with the Program, or
  - » Sell, trade, barter for or return for credit any XEOMIN provided under the Program.
- The Program may be modified or discontinued at any time, without further notice.

Print Healthcare Provider Name _____

Healthcare Provider Signature _____ Date _____

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Patient First Name _____ Last Name _____ Date of Birth (MM/DD/YYYY) _____

7. HIPAA AUTHORIZATION TO USE AND DISCLOSE INFORMATION *(to be completed by Patient/Legal Guardian)*

By signing below and submitting this Application, I understand and authorize my/the patient's health care provider and health insurer to release my/the patient's protected health information, including information contained in this Application or my/the patient's medical records or benefits information, to Administrator and to Merz (Administrator/Merz) and authorize Administrator/Merz to contact me in connection with this Program. Further, I authorize Administrator/Merz to contact my/the patient's insurer and physician to confirm coverage for XEOMIN and eligibility for this Program. I authorize Administrator/Merz to use my/ the patient's information to administer the Program and to communicate with me, my/patient's physician, and my/patient's insurer. I further authorize Merz or parties acting on its behalf to use my protected health information for marketing activities or to contact me/the patient in the future for market research, clinical trials, and other information it believes to be of interest to me/the patient. I understand that participation in the Program is voluntary and my/patient's health care provider or insurer may not require me to sign this authorization as a condition of treatment or coverage; however, if I do not sign this authorization, I/the patient will be unable to participate in the Program. This authorization will be valid for one (1) year or until my/the patient's participation in the Program ends through my/the patient's cancellation, unless a shorter time is required by applicable law. I also understand and agree: (i) I can obtain a copy of this signed authorization; (ii) I/the patient may revoke this authorization in writing at any time by email to Merz@lashgroup.com, but I/patient will no longer be permitted to participate in the Program after the date the authorization is revoked and my revocation will not impact uses or disclosures of information already made in reliance on this authorization; and (iii) once my/the patient's protected health information has been disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and no longer protected by federal privacy laws.

Patient Name (Print) _____ Date _____

Patient/Legal Guardian Signature *(If the Patient cannot sign, the Patient's personal representative must sign below)* _____

Patient Representative or Legal Guardian Name (Print) _____ Patient Representative or Legal Guardian Signature _____

Relationship to the Patient, and authority to make medical decisions for Patient _____

A copy of this form must be provided to the Patient/Legal Guardian.

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MERZ THERAPEUTICS