VIVUS

pancreaze® (pancrelipase) DELAYED-RELEASE CAPSULES | pancreaze engage

VIVUS Patient Assistance Program Application

Toll Free Phone 1-855-751-5540
Toll Free Fax 1-877-202-0127

PROGRAM DESCRIPTION

The purpose of this enrollment tool is to collect information required for enrollment in the Pancreaze Patient Assistance Program offered by VIVUS (the Program). The Program provides medication at no cost to eligible patients. This enrollment form is for patients who have been prescribed PANCREAZE® (pancrelipase) Delayed-Release Capsules and would like to apply to receive the medication free of charge from VIVUS if they qualify. VIVUS will determine a patient's eligibility for assistance based on the program requirements.

To apply for assistance all information must be complete and include the following:

1. Complete page 1 and sign and date the Patient Authorization and Declaration on page 2
2. Ask your Healthcare Professional (HCP) to complete page 3 and sign the bottom of page 3
3. Include a copy of the **front and back** of your insurance card if you have insurance
4. Include a copy of your most recent 1040 or 1040EZ Federal tax return (or other appropriate documentation of household income)

Fax to: 1-877-202-0127 or Mail to:
8000 Corporate Center Drive Suite 200 Charlotte, NC 28226
If you have any questions, call: 1-855-751-5540

PATIENT INFORMATION

Name First:_____ Middle:_____ Last:_____
Social Security Number: ___ – ___ – ____ Gender: Male ○ Female ○
Mailing Address:_____ City:_____ State: __ Zip:_____
Preferred Phone: ___ – ___ – ____ ☐ OK to leave voicemail? Date of Birth ___/___/____

Number of people, including applicant, who are dependent on household income:_____ Total household annual income:_____

Email:_____

ALLERGY& HEALTH INFORMATION

List any known drug allergies:_____
List of other current medications:_____
Exocrine Pancreatic Insufficiency (EPI) Diagnosis:_____

- ϒ EPI due to Cystic Fibrosis
- ϒ EPI due to Chronic Pancreatitis
- ϒ EPI due to another condition

COVERAGE INFORMATION(CHECK ALL THAT APPLY)

Insurance Information		Group or Policy Number
Medicaid:	☐ Enrolled	
Medicare:	☐ Enrolled	
Medicare Part D:	☐ Enrolled	
Private Insurance:	☐ Enrolled	
VA or military:	☐ Enrolled	
State Assistance Program for Med	☐ Enrolled	

PATIENT AUTHORIZATION AND DECLARATION-Patient should keep a copy of this page

By signing below, I authorize my health care providers, pharmacy, and insurer providers to disclose and transmit information about me, my medical condition, treatment, insurance coverage, and financial information to VIVUS and any third party engaged to assist VIVUS in administering the Pancreaze Patient Assistance Program (the "Program") (collectively, "VIVUS"), for the purpose of (1) enrolling me in the Program, (2) verifying my eligibility for the Program, both initially and throughout my participation in the program, (3) providing me with the Program services, and (4) administering, evaluating and improving the Program.

I understand that once my information has been disclosed in reliance upon this authorization, it may no longer be protected by federal privacy regulations and may be re-disclosed, however, VIVUS agrees to protect my information by using and disclosing it only as described in this authorization or as required or permitted by law.

This authorization will remain in effect for 3 years, or sooner as limited by state law. I understand that I have the right to revoke this authorization at any time by writing to HarborPath Direct, Woodfield Corporate Center, 8000 Corporate Center Dr., Suite 200, Charlotte, NC 28226, but my revocation will only prevent further disclosure of my information after notice of my revocation has been received and will not affect any uses already made in reliance on this authorization. I further understand that revocation would end my eligibility for the Program.

I understand I may refuse to sign this authorization and that if I refuse, my eligibility for health plan benefits and treatment by my healthcare providers will not change, but I will not have access to this Program. I also understand that I have a right to receive and/or make a copy of this authorization after I have signed it.

I promise that:

- The information provided in this application is correct and complete to the best of my knowledge.
- I will notify VIVUS within 30 days if there is any change in my financial status or insurance coverage by writing to the address provided above or by calling toll free at 1-855-751-5540.
- I will not seek reimbursement for any medication(s) I receive under the Program from any government program, or third-party payor.
- If I am a member of a Medicare Part D plan, I will not apply or claim the cost of any Program drug(s) toward my true out-of-pocket costs (TrOOP);

Signature (Patient or Legal Representative) Date

If Legal Representative, Print Name and Indicate Relationship:

PHYSICIAN/PRESCRIBER INFORMATION

Name First: Middle: Last:
Business/Facility Name: Phone – – Fax – –
Office Contact Name First: Middle: Last:
Mailing Address: City: State: Zip:
Professional Designation: NPI Number:
DEA #: State License #: Email:

PRESCRIPTION: MUST BE COMPLETED BY A LICENSED PERSCIRBER

PANCREAZE® (pancrelipase) Delayed-Release Capsules

	Directions	Quantity	Refill
ϒ 2,600 Lipase Units			
ϒ 4,200 Lipase Units			
ϒ 10,500 Lipase Units			
ϒ 16,800 Lipase Units			
ϒ 21,000 Lipase Units			

Other health conditions/ diagnoses:

PLEASE SUBMIT PRESCRIPTIONS ACCORDING TO YOUR SPECIFIC STATE LAWS, RULES AND REGULATIONS

PHYSICIAN/PRESCRIBER CERTIFICATION

By my signature, I confirm:

1. To the best of my knowledge, the information I have provided on this form is complete and accurate.
2. No claim for reimbursement may be made to any third-party payer (e.g. Medicaid, Medicare, private insurance, etc.) for payment for product provided under the Program.
3. I am prescribing PANCREAZE® to treat this patient's Exocrine Pancreatic Insufficiency (EPI).
4. My State license is currently in good standing, I am not prohibited from participating in Federally-funded healthcare programs, nor am I on the List of Excluded Individuals/Entities maintained by the HHS Office of Inspector General.
5. I authorize VIVUS and its designees to determine patient eligibility for the Program and for auditing purposes.
6. To the best of my knowledge this patient does not have prescription drug insurance coverage for PANCREAZE®.

I authorize the Program to forward this prescription to a dispensing pharmacy on behalf of myself and my patient.

Signature (Prescriber) Date / /