tolmar TOTAL SOLUTIONS®

Phone: 1-844-TOLMAR1 (1-844-865-6271)
Fax: 1-844-TOLMAR2 (1-844-865-6272)

Eligard®
(leuprolide acetate) for injectable suspension

Patient Services Form

1 Fulfillment Preferences

☐ Physician Buy & Bill
☐ Specialty Pharmacy Fulfillment Only
☐ Automatically triage to specialty pharmacy if required
☐ Patient Assistance Program

Patient Information

FIRST NAME	MIDDLE INITIAL	LAST NAME	
ADDRESS			
CITY	STATE	ZIP CODE	HOME PHONE # ( ) –
DOB / /	GENDER ☐ MALE ☐ FEMALE	SOCIAL SECURITY # – –	

Prescriber Information

FIRST NAME	LAST NAME	SUFFIX		
NPI	TAX ID	PTAN	DEA #	STATE LIC. #

Facility Information

PRESCRIBER SPECIALTY	FACILITY NAME			
FACILITY ADDRESS				
CITY		STATE	ZIP CODE	FACILITY TYPE ☐ Physician's Office ☐ Hospital Outpatient ☐ Hospital Inpatient
CONTACT	PHONE # ( ) –	FAX # ( ) –		

Diagnosis & Prescription Information

☐ 7.5 MG – 1 Month, Inject 7.5 mg SC every one month
☐ 30 MG – 4 Month, Inject 30 mg SC every four months
☐ 22.5 MG – 3 Month, Inject 22.5 mg SC every three months
☐ 45 MG – 6 Month, Inject 45 mg SC every six months

QTY	REFILLS	ICD-10/DX	CPT
		☐ C61: Malignant neoplasm of prostate ☐ Other: _____	☐ 96402: Chemotherapy administration; subcutaneous or intramuscular; hormonal anti-neoplastic ☐ Other: _____

2 HIPAA Consent

Do you have the patient's HIPAA consent on file authorizing the release of the patient's identification and insurance information to Tolmar Pharmaceuticals and their agents and representatives for benefit verification and Tolmar Total Solutions purposes?

☐ YES ☐ NO (Confirmation of written patient HIPAA consent is required for benefits verification & patient assistance services)

2 HIPAA Consent (continued)

By signing this form I hereby confirm that I have properly obtained the required consent and authorization (if needed) that are required under Federal HIPAA and other State and Federal privacy laws, to release and share certain protected health information to the Tolmar Patient Assistance Program ("PAP") managed by its contracted third party ("the PAP"). I further certify that the information provided is complete and accurate to the best of my knowledge.

I verify that I am a practicing healthcare provider, authorized to request, prescribe and receive prescription medications at the address identified herein. I will notify the PAP if any changes occur to my status in this regard. I further verify that I understand the PAP program may make product available to eligible patients (as determined by the PAP), and ship such product to me designated for a specific approved patient's use. I further verify that I am prescribing the medication identified and ordered for my patient through the PAP and will only dispense the product received for the specific patient identified and enrolled in the PAP. I may not dispense or use product provided by the PAP for any other purpose.

I further verify that I shall not bill, sell, seek reimbursement from the government or any third party or file any claim for the drug product provided under the PAP. I also acknowledge that my patient's approval and participation in the PAP was not in exchange for any promise or reward or other explicit or implicit agreement with Tolmar for or relating to past or future use, ordering, prescribing, recommending or referring of any Tolmar products.

Prescriber Return Clause
I confirm and agree that if the patient does not show up for the PAP medication or is otherwise unavailable to receive the product provided by the PAP within 30 days from receiving the PAP drug product, I must contact the PAP and arrange for the return of the product. I will call 866-738-0960 to obtain assistance and instructions on PAP returns.

▶ / /

PRESCRIBER SIGNATURE **DATE**

3 Insurance Information

PRIMARY MEDICAL INSURANCE				
PAYER NAME		CARDHOLDER NAME		
POLICY #	GROUP #	EFFECTIVE DATE / /	PHONE # ( ) –	
SECONDARY MEDICAL INSURANCE				
PAYER NAME		CARDHOLDER NAME		
POLICY #	GROUP #	EFFECTIVE DATE / /	PHONE # ( ) –	
PRESCRIPTION INSURANCE				
PAYER NAME		CARDHOLDER NAME		
POLICY #	GROUP #	EFFECTIVE DATE / /	PHONE # ( ) –	

4 For Ohio Licensed Healthcare Practitioners Only

Please print/type your Terminal Distributor of Dangerous Drug (TDDD) license number (if applicable): _____

Please visit the Ohio State Board of Pharmacy website (www.pharmacy.ohio.gov) for additional information on when a prescriber must hold a TDDD license.

Are you exempt from TDDD licensure? ☐ **YES** ☐ **NO**

By checking "Yes," you attest that you meet one of the licensing exemptions under ORC 4729.541. Exemptions include, but are not limited to: (1) prescribers who are sole proprietors; (2) business practices with a sole shareholder (per Ohio law, group practices with multiple shareholders are not exempt); and (3) dentists licensed by the Ohio Dental Board. Please visit the Ohio State Board of Pharmacy website for additional information. By checking "No," you attest that you have provided a valid TDDD license number above. Your signature serves as attestation and that you have the appropriate TDDD licensure or qualify under an exemption.

5 Patient Assistance Program

TOTAL # OF PEOPLE IN THE HOUSEHOLD	ANNUAL HOUSEHOLD INCOME	
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ OTHER:	$	

REPRESENTATIVE/ORGANIZATION NAME	RELATIONSHIP	PHONE #
		( ) –

AUTHORIZATION FOR DISCLOSURE OF INFORMATION

This "Authorization" is hereby provided for the purpose of providing permission for the use and disclosure of my protected health information, including but not limited to my name, medication be treated for, application into the Tolmar PAP program, insurance and financial information and other relevant information. I hereby request and authorize my healthcare providers and insurers to disclose any healthcare, treatment, insurance and other information that pertains to my medication to Tolmar Pharmaceuticals, Inc. and its third party vendors ("Tolmar") for the purpose of (a) processing my application for access to the Tolmar Patient Assistance Program ("PAP"); determining my eligibility in the PAP; (c) determining my ongoing eligibility status and future transfers, withdrawals or cancellations, including case reviews, audits, assessments and other verification procedures. Upon receipt of my healthcare information, I hereby authorize Tolmar to disclose such information to my healthcare providers and insurers as necessary to determine my eligibility in the PAP and if approved, to notify of enrollment in the PAP. I understand that my future treatment, prescriptions and medical care from healthcare providers and insurers are NOT contingent upon signing this Authorization and that I am not required to sign this Authorization. However, I understand that if I do not sign this Authorization I will not be eligible for the PAP. I further understand that I may cancel this Authorization by notifying Tolmar at 844-865-6271. Upon providing such notification, Tolmar may not further disclose my health information and I will not be eligible for the PAP as of the notification date.

This Authorization shall be valid for 10 years from the date set forth below, unless required to be shorter by State Law. Upon signing this Authorization my health information will not longer be protected under HIPAA and is subject to re-disclosure

PATIENT ATTESTATION FOR MEDICARE OR MEDICAID PRESCRIPTION DRUG PLAN

If I am eligible for a Medicaid Prescription Drug Plan, but that plan does not cover the Tolmar drug products, I may be eligible for the PAP if:

I agree I will file no claim with any government or commercial insurer for the drug product provided to me under the PAP (e.g. Medicare, Medicaid, Puerto Rico's Government Health Plan Mi Salud, or any Commercial Insurer).

I obtain confirmation from Medicaid that it will not cover the Tolmar drug product. (If the Medicaid Program covers a portion of your cost, you will not be eligible for the PAP).

If eligible, I have applied for Puerto Rico's Government Health Plan Mi Salud and have been denied.

I agree to send notification to my Medicaid provider that I have received free product under the Tolmar PAP in order to ensure that no payment for the product is made under the Medicaid Plan.

I further verify that if my insurance or financial information changes in any material respect (e.g. change in employment, insurance/medical expenses or total household number), I will immediately notify Tolmar.

CERTIFICATION FOR PATIENT ASSISTANCE

My signature below confirms that I am applying for free drug product under the Tolmar Pharmaceuticals, Inc. ("Tolmar") Patient Assistance program ("PAP"). I understand that I am not entitled to free product but that I may apply and if eligible, as determined solely by Tolmar, I may receive product at no cost. I understand that Tolmar has no obligation to provide me free product and I hereby waive any and all claims of liability of Tolmar in relation to the PAP program and services provided. I understand that by signing below, I am not guaranteed eligibility. I verify that the information I have provided to the PAP is true and complete to the best of my knowledge. I further verify that if eligible, I will not file any claim or seek any reimbursement for the free product provided to me. I further certify that the prescriber writing the prescription for Tolmar product was selected by me and not referred by Tolmar or any of its agents. If eligible, I understand that Tolmar may terminate eligibility at any time and without any advance notice to me. I further understand, that even after I am determined to be eligible, Tolmar is under no obligation to provide product and may at any time cancel my eligibility for any reason or no reason whatsoever. I further verify that if my insurance or financial information changes in any material respect, I will immediately notify Tolmar.

▶ _____ / / _____ / /

SIGNATURE OF PATIENT **PATIENT SOCIAL SECURITY NUMBER** **DATE OF BIRTH** **DATE**

Instructions

Reimbursement Connection And Resource Connection

- Please **complete all fields** in Sections 1- 3 for Tolmar Total Solutions reimbursement assistance
- For Ohio Prescribers, please also complete Section 4
- TOLMAR Total Solutions **does not** require income documentation, household size information or patient signature for reimbursement assistance
- In Section 3, the **licensed Prescriber must indicate if there is a patient consent on file**
- **For the Patient Assistance Program, please complete sections 1,2,3 and 5 (If an Ohio Prescriber, please also complete section 4)**

Patient Assistance Program

Program Eligibility

- An application must be submitted for each patient
- Patient must be diagnosed with an FDA approved indication for the product
- Patient must be a resident of the United States
- Patient must have no insurance coverage or be functionally uninsured
- Patients with Medicare, Medicaid, Mi Salud and other government insurance coverage for ELIGARD® may not be eligible
- Patient must be under the care of a licensed healthcare provider who is authorized to prescribe, dispense, and administer medicine in the US. State Lic.# and DEA are required
- Patient must meet the following financial criteria:
  - Annual household income of ≤500% of current Federal Return Poverty Level (FPL) for oncology/ hematology products
- If there has been a change in status (loss of income, medical expenses, insurance coverage, change in household size) during the tax year, please submit proof of status change for consideration

Documentation Requirements

- Please complete Sections 1-4
- If insured, proof of out of pocket medical expenses is required and a detailed list with invoicing/receipts must be submitted
- Please submit a copy of: the denial, dates of service and total dosage
- Please submit a copy of Medicare card or letter of Medicaid and/or Social Security denial, if applicable
- Please **have the patient sign the bottom of Section 5** for the Tolmar Patient Assistance Program
- **Proof of income is required:**
  Submit an acceptable form of income documentation (If not required to file a US income tax return, I RS Form 4506-T may be required)

  Choose one option:

  1. Copy of W-2 (from all employers) or most recently filed U.S. Income Tax (IRS Form 1040, 1040A, 1040EZ, 1040NR, or 1040PR) **or**
  2. Copy of most recent pay stub plus most recent US Income Tax Return, **or**
  3. Copy of most recent IRS Form-1099 plus most recent US Income Tax Return, **or**
  4. Copy of most recent SSA-1099 plus most recent US Income Tax Return