

The ProStraCARE<sup>™</sup> Patient Assistance Program (the “Program”) was designed to assist **uninsured** individuals who have no public or private prescription coverage (e.g., Medicaid, Medicare prescription drug coverage, other charitable organizations) for SANCUSO<sup>®</sup>. All applications are reviewed on a case-by-case basis.

### PROGRAM ELIGIBILITY

- Legal resident of US and its territories
- Must not be eligible for or have prescription drug coverage through any private or public prescription coverage program including Medicaid and Medicare
- Annual household income must be at or below 300% of the current federal poverty level
- Must submit recent federal tax return along with the application. If you do not file taxes, alternate proof of income will be required

### APPLICANT CHECKLIST

- Complete the **Applicant Information** and **Financial Information** sections of the application in their entirety (incomplete applications will be returned as denied)
- Sign the Applicant Declaration section
- Sign the separate Patient Authorization to Share Health Information form (no stamped signatures will be accepted)
- Include a copy of a recent federal tax return. If you do not file taxes, the documentation support submitted should match with the selected income values on your application. Acceptable documents include:
  - W2 forms
  - Pay statements
  - Social security, pension, or retirement statements
  - Bank statements
  - Statements of interest, dividends, or other income
- Send all information to the fax number and/or mailing address listed above (please be sure the physician section is completed before submitting your application)

### PHYSICIAN CHECKLIST

- Must have completed the ProStraCARE<sup>™</sup> enrollment form and received a denial for coverage for SANCUSO<sup>®</sup>
- Complete the **Therapy and Physician Information** sections of the application in their entirety
- Sign the Physician Certification (no stamped signatures will be accepted)

### ProStraCARE<sup>™</sup> PATIENT ASSISTANCE PROGRAM COORDINATOR RESPONSIBILITY

- Review the application for completeness
- Determine applicant qualification based on preestablished program criteria
- Notify applicant and physician of outcome of acceptance into the program
- Upon qualification, notify program distributor and/or applicable pharmacy of patient eligibility for ProStraCARE<sup>™</sup> Patient Assistance Program



Patient Assistance Program Application

1011 Warrenville Rd, Suite 115
Lisle, IL 60532
Phone: (800) 726 2876 Fax: (866) 258 7480

Applicant Information

Form with fields for First Name, M.I., Last Name, Address, City, State, ZIP Code, Daytime Phone, OK to Leave Message?, Date of Birth, SSN, Gender, Single, Married, Widowed, Divorced, US Resident.

Financial Information

Table for financial information with columns for Salary/Wages/Unemployment, Pension/Retirement, Social Security, Disability, Alimony/Child Support, Other. Includes checkboxes for tax return status and household size field.

Applicant's Certification: My signature certifies that 1) I understand and I have signed the attached Patient Authorization regarding the release of my Protected Health Information (PHI) (including its use and disclosure purposes) to the ProStraCARE™ Patient Assistance Program (the "Program"); 2) I am a legal resident of the US and its territories; 3) The information provided in this application is current, complete, and accurate; 4) I do not have prescription drug coverage of any kind, including without limitation any private insurer or public, federal, state, Medicaid or Medicare Part D health care program; 5) Upon approval, I authorize ProStrakan, its vendor Cardinal Health, Inc. and any other affiliated companies, subcontractors, vendors and/or partners that help with the Program to forward my information to a dispensing entity on my behalf; 6) I understand that, once dispensed, the dispensing entity will send the medication to me; 7) I shall not seek reimbursement from any source, including any public health program or private insurer for any medication dispensed through the Program; 8) All information provided as part of this application is for the express and sole purpose of qualifying for eligibility to receive SANCUSO® at no cost through the Program; 9) I understand that Program eligibility is subject to ProStrakan's discretion and ProStrakan reserves the right to modify or terminate the Program at any time; 10) I hereby release and forever discharge ProStrakan and its vendor Cardinal Health, Inc. from any and all liability related to the Program.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Therapy Information

Form with fields for Date of first cycle treated with SANCUSO® and Future date(s) with date format lines.

Physician Information

Form with fields for Physician Name, License #, License Expiration Date, Practice Name, Address, City, State, ZIP, Office Contact Name, Phone #, Fax #.

Physician Certification: My signature certifies: 1) I am duly licensed and authorized under applicable law to prescribe the medication requested in this application to the patient listed above (the "Patient"); 2) The information provided above is complete and accurate; 3) If this Patient Assistance Program Application is approved, I understand that I will need to forward a prescription for SANCUSO® to the appropriate pharmacy for dispensing to the Patient.

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_ (original signature required)

**PATIENT AUTHORIZATION TO SHARE HEALTH INFORMATION**

I, \_\_\_\_\_, authorize my physician(s), my health plan or insurers, and any other healthcare providers to give to ProStrakan, Inc., its vendor Cardinal Health,\* the administrator of ProStraCARE<sup>™</sup>, and/or any other affiliated companies, subcontractors, vendors, and/or partners (collectively "ProStrakan") that help with my enrollment into and for proper administration of ProStraCARE<sup>™</sup> in determining coverage for the prescribed ProStrakan 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).

I authorize ProStrakan, Inc. and Cardinal Health to use and/or disclose my information for the following purposes:

- Determine whether my health insurance benefits will pay for ProStrakan'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 ProStraCARE<sup>™</sup> or to help find other ways to pay for those product(s), 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 ProStraCARE<sup>™</sup> and its sponsor, ProStrakan, Inc., 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 ProStrakan, Inc. 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 Cardinal Health (the 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 ProStraCARE<sup>™</sup> 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

**By:** \_\_\_\_\_

**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.**

\*Cardinal Health refers to Cardinal Health, Inc. and any of its subsidiary companies.