Application

Bayer understands that sometimes people face financial challenges, and we are here to help. The Bayer US **Patient Assistance Foundation** is a charitable organization that helps eligible patients get their Bayer prescription medicine at no cost.

How do I know if I may be eligible?

You may be eligible for the Bayer US **Patient Assistance Foundation** free drug program if you:

- Live in the United States or Puerto Rico
- Meet certain income limits
- Don't have insurance, or your Bayer prescription medicine is not covered

How do I apply?

- Complete and sign the **Patient Information Section**
- Ask your doctor or healthcare professional (HCP) to complete and sign the **Healthcare Professional Section**
- Make a copy of the completed and signed application for your records.
- Fax or mail the complete application for review by the program.

Where do I send my completed application?

The completed and signed application can be submitted by fax or mail:

Fax: 1-866-575-6568

Mail: Bayer US Patient Assistance Foundation
P.O. Box 5670, Louisville, KY 40255

Visit Website
www.patientassistance.bayer.us

Questions? Call
1-866-228-7723

Bayer US **Patient Assistance Foundation**
P.O. Box 5670, Louisville, KY 40255 / 1-866-2BUSPAF (228-7723)

Patient Information Section

(The patient information section may be completed by you or a caregiver)

Please check one of the following boxes: ☐ I am a new patient ☐ I am re-enrolling

Your Name and Contact Information

Name _____ (First) _____ (Last) Date of birth ____/____/____ (mm / dd / yyyy) Sex ☐ Male ☐ Female

Address _____ City _____ State _____ Zip code _____

Preferred contact ☐ Home _____ ☐ Cell _____ ☐ Work _____

Your email address _____

Caregiver (optional)

Name _____ (First) _____ (Last) Telephone number _____

Relationship _____

I have spoken to my caregiver and they agree to receive non-marketing calls from the Bayer US Patient Assistance Foundation (the "Foundation") at the number provided, and I authorize the Foundation to speak to my caregiver about my health condition and regarding the program.

Your Household Income

How many people live in your household and are dependent on your household income (include yourself)? _____

What is your total household income? $ _____

Patient Insurance Information - Do you have insurance through any of these providers. Check all that apply

☐ Medicare: ☐ Part A ☐ Part B ☐ Part C/Medicare Advantage ☐ Part D ☐ Part D LIS/Extra Help

☐ Medicaid ☐ VA or Military ☐ Private Insurance ☐ None ☐ Other: _____

	Primary Insurance	Secondary Insurance	Prescription Insurance
Insurer name			
Plan name			
Plan phone number			
Name of plan Subscriber			
Subscriber relationship to patient			
Membership ID/Policy #			
Group			
Medicare Membership ID (11 digit alpha/numeric) #	— — — — - — — — - — — — —		☐ Not applicable

Please note:

- If you are age 65 and over, have income less than 150% of the federal poverty level, you will be asked to provide proof of denial for the Medicare Part D Low Income Subsidy Extra Help Program.
- Medicaid-eligible patients who are not enrolled in Medicaid will be required to submit proof of denial from the Medicaid program.

To prevent delays, please include copies (front and back) of all insurance card(s). This includes primary, secondary, and prescription insurance. If you are enrolled in Medicare Part D, your membership ID number is required before this application can be processed.

An incomplete form will result in a processing delay or application denial. Your application cannot be considered without a fully completed and signed form.

Patient authorization to share health information

I agree to allow my healthcare providers and health insurers to give the Bayer US Patient Assistance Foundation free drug program, Bayer and its agents my personal and medical information, including healthcare condition, diagnosis and medicines, for the purposes listed below:

- (i) Determine if I am eligible for the program, (ii) provide me with free medicine throughthe Bayer US Patient Assistance Foundation free drug program if I am eligible to participate, and (iii) comply with any laws that may require the use or disclosure of my information.
- Contact me or my healthcare provider for additional information to evaluate any adverse event or product complaint that I report or that my provider reports on my behalf.
- Contact me to ask for feedback on the quality or customer service of the program.
- Proper management and administration of the program and as permitted or required by applicable law.

I understand:

- Application to the program is entirely voluntary and I may choose to not complete or sign this form. My decision will not change the way my healthcare providers or health insurers treat me. However, if I do not complete and sign this application, I will not be able to participate in the Bayer US Patient Assistance Foundation free drug program.
- Privacy laws may not prevent further disclosure of my information after it has been provided to the program, Bayer, their agents, or third-party providers authorized to administer the program.
- This authorization to provide my personal information will continue until I am no longer enrolled in the program, or in 1 year if a shorter period is required by law, or until I may choose to cancel my authorization, which I may do at any time.
- I may opt-out of being contacted for market research feedback, support purposes, and still enroll in the program.
- I can cancel my authorization at any time by writing to the Bayer US Patient Assistance Foundation, PO Box 5670, Louisville, KY 40255. Cancelling my consent will not have any effect on information given to or used by the program or its agents before the program received my written notice to cancel the consent.
- I should keep a copy of this form. I also can get a copy by contacting the program at 1-866-2BUSPAF (228-7723).
- To report any adverse events, product technical complaints, or medication errors, contact: Bayer at 1-888-842-2937, or send the information to DrugSafety.GPV.US@bayer.com.

Please complete and sign the section below

I acknowledge that submission of this application does not guarantee eligibility in the Bayer US Patient Assistance Foundation. By signing below, I attest that the responses I provided on page [2] are accurate and that I have read, understand, and agree to the release and use of my personal information pursuant to the terms of this HIPAA Patient Authorization.

Printed name of patient

Signature of patient (or legal representative)

Today's date MM/DD/YYYY

Printed name of legal representatitve (if applicable)

Relationship to patient (if applicable)

By applying for the **Bayer US Patient Assistance Foundation** free drug program, I understand and agree:

- There is no charge to participate and my participation in the program is not contingent on any requirement to purchase or use any Bayer product.
- The program may change or end at any time.
- I will not sell or trade any medicine that I get through this program.
- I will notify the program within thirty (30) days if there is any change in my income, health insurance, eligibility to enroll in Medicare Part D, or any other reason that may affect my eligibility.
- I will not seek to be reimbursed or receive credit from my insurance provider, including Medicare Part D plans, for medicine I receive through the program.
- I will not seek credit for medicine from the program toward my true out-of-pocket expenses under Medicare Part D.
- The information I provided in this application is correct and complete.

Financial Eligibility Authorization

☐ By checking this box, I am providing 'written instructions' under the Fair Credit Reporting Act to the program, including its agents, administrators, and service providers, authorizing the program to obtain information from my credit profile and/or other information from Experian Health. I authorize the Bayer US Patient Assistance Foundation, including its agents, administrators, and service providers, to obtain such information solely to determine my eligibility to participate in the program.

Bayer US Patient Assistance Foundation

P.O. Box 5670, Louisville, KY 40255 / 1-866-2BUSPAF (228-7723)

Healthcare Professional Section (To be completed by your healthcare professional)

HCP name _____ (First) _____ (Last) Specialty _____

Address _____ City _____ State _____ Zip code _____

Phone number _____ Fax _____

DEA # _____ State license # _____ NPI # _____

Office contact _____ Phone _____ Fax _____

Office email address _____ Preferred communication method: ☐ Email ☐ Fax

Patient Information

Patient name _____ (First) _____ (Last) Date of birth _____/_____/_____ (mm / dd / yyyy)

Patient Address _____

List or attach other current medications prescribed _____

Known drug allergies ☐ Yes ☐ No List _____

Prescription

Medication Brand Name	Strength	Directions	Quantity	Number of refills
				☑ 1 year ☐ Other_____

Nubeqa	Strength	Directions	Quantity	Number of refills
Nubeqa	300 mg		☐ 30 day supply ☐ 60 day supply ☐ Other_____	☐ 1 year ☐ Other_____

Adempas

Starting dose*:

☐ **Adempas 1 mg. tablet by mouth three times a day**

☐ Adempas 0.5 mg. tablet by mouth three times a day

Quantity
☐ 30 day supply
Refills:_____

Titration schedule:

Please check box for all dosages to be incorporated:

☐ Based on patient's response per clinical evaluation of the physician or the nurse in consultation with the physician, the pharmacy is to provide the Adempas strength to accomodate titration needs of therapy.

Adempas Tablets: 0.5 mg., 1 mg., 1.5 mg., 2 mg., 2.5 mg.

Directions: If systolic blood plessure is >95 mmHg and there are no signs/symptoms of hypotension, up titrate by 0.5 mg. 3 times per day at intervals no sooner than 2 weeks to the highest tolerated dosage up to maximum of 2.5 mg. 3 times per day. If at any time, the patient has symptoms of hypotension, decrease the dosage by 0.5 mg. 3 times daily. The established individual dose should be maintained.

Other special instructions:

Titration Quantity: ☐ 30 day supply Refills:

Adempas Maintenance Dose	Strength	Directions	Quantity	Number of refills
				☐ 1 year ☐ Other_____

Please check here for a replacement unit for: ☐ Kyleena®, ☐ Mirena®, or ☐ Skyla®. Date of Service

HCP Authorization

I certify that I am the healthcare professional who prescribed the medication requested in this application for the sole benefit of the named patient, and that my decision to prescribe was based on my independent professional judgement. I authorize the Bayer US Patient Assistance Foundation free drug program (the "Program"), and agents acting on its behalf to use my provider information, including National Provider ID, in the eligibility assessment process, and to forward this prescription, as necessary, to a dispensing pharmacy.

In addition to the above, my signature below certifies the following:

- I will not charge patients any fee for or related to their application, enrollment in the Program, any co-payment, or other cost-sharing amount related to free drug provided under the Program.
- No claim for payment for any product provided through the Program may be submitted to any third-party payer, including private insurers, Medicaid or Medicare.
- This medication provided by the Program will only be utilized by the patient named on this form, and will not be offered for sale, trade, barter, or returned for credit.
- The patient applying for assistance through the Program is being treated in an outpatient setting.
- To the best of my knowledge, the information provided on this form is current, complete and accurate.

I understand and acknowledge that (i) submission of the application does not guarantee the patient's eligibility in the Program; (ii) the Program has the right to discontinue the Program at any time; and (iii) medication provided through the Program for enrolled patients is not contingent on any past, present or future prescriptions for this or any other Bayer product.

Required Prescriber's Signature (Dispense as Written):

_____

Date (required):_____/_____/_____ (mm / dd / yyyy)

Please make sure every part of the Healthcare Professional Information section is completed.