ParaGard® Patient Assistance Program Eligibility Requirements

A ParaGard unit will be provided free of charge to patients who meet program eligibility requirements:

- Patient must be a US resident
- Patient must be 18 years of age or older
- Patient’s gross annual household income must be at or below 200% HHS Poverty Guidelines*
- Patient must provide proof of gross annual household income
  - Financial documentation must be included with the Qualification Form.
  - Proof of income includes copies of both:
    - a) federal tax return (Form 1040 or 1040EZ) for prior tax year, and
    - b) all other recent documents that show income paid to patient (and/or spouse if married), such as: wage and tax statements (W-2 forms), Social Security, Pension, or Railroad Retirement statements (SSA-1099 or similar), Statements of interest, dividends, or other income (1099-INT, 1099, 1099-DIV, or other forms)
- Patient cannot have any private, third-party or government insurance that covers ParaGard in whole or in part, including Medicare, Medicaid, or any state or local programs.

Additional requirements:

- Program Qualification Form must be completed in its entirety by the healthcare professional caring for the patient.
- Both patient and healthcare professional must sign the Qualification Form in the appropriate section
- Patient must sign and submit the Authorization to Disclose Form
- Healthcare professional must have a current valid state license

* Income criterion is based on Health and Human Services Poverty Guidelines. These guidelines may be revised each new year, usually around February. Website is:  http://aspe.hhs.gov/poverty/index.shtml
ParaGard® Patient Assistance Program  
250 Phillips Blvd, Ste 250, Ewing, NJ 08618  
Phone: 1-800-425-3122  Fax: 1-800-685-2577  
www.paragard.com  

Qualification Form

PATIENT INFORMATION (Please Print)  
Patient must be a U.S. resident

<table>
<thead>
<tr>
<th>First Name:</th>
<th>__________</th>
<th>MI:</th>
<th>Last Name:</th>
<th>__________</th>
<th>Social Security #:</th>
<th>________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td></td>
<td></td>
<td>City:</td>
<td>__________</td>
<td>State:</td>
<td>________</td>
</tr>
<tr>
<td>Date of Birth: (mm/dd/yyyy)</td>
<td>__________</td>
<td>(Patient must be 18 years of age or older)</td>
<td>Phone:</td>
<td>__________</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Current gross annual household income: $ __________  
Number of household members dependent on income (including patient) __________  
Number of children __________

Patient financial documentation must be included with this application. Proof of income includes copies of both: a) your federal tax return (Form 1040 or 1040EZ) for prior tax year, and b) All other recent documents that show income paid to you (or your spouse if married), such as: wage and tax statements (W-2 forms), Social Security, Pension, or Railroad Retirement statements (SSA-1099 or similar), Statements of interest, dividends, or other income (1099-INT, 1099, 1099-DIV, or other forms)

Patient's insurance and prescription coverage (in whole or in part)  
Check all that apply.

- Medicare  
- Medicaid  
- Private Insurance, HMO or PPO
- State or Local Government Programs
- Other

- Includes Rx

If insurance includes Rx coverage, name of carrier: __________

☐ I certify that I do not have insurance coverage either in whole or in part for ParaGard®

PATIENT'S VERIFICATION AND SIGNATURE

I verify that the information provided in this application is complete and accurate. I understand that completing this form does not ensure that I will qualify for this program. I certify that I do not have private, third-party or government insurance coverage (either in whole or in part) for ParaGard. I understand that the program administrators reserve the right any time and without notice to modify the application form, modify or discontinue any or all of the program and the related eligibility criteria; or terminate assistance provided by the program at any time. I authorize Duramed Pharmaceuticals, Inc. to use the information on this application to process my request and the use of my Social Security number for identification purposes and record keeping.

Patient's Original Signature: __________  
Date: (mm/dd/yyyy) / / / __________

HEALTHCARE PROFESSIONAL INFORMATION (Please Print)

<table>
<thead>
<tr>
<th>First Name:</th>
<th>__________</th>
<th>MI:</th>
<th>Last Name:</th>
<th>__________</th>
<th>Office Contact Name:</th>
<th>________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Street:</td>
<td>__________</td>
<td></td>
<td>City:</td>
<td>__________</td>
<td>State:</td>
<td>Zip Code:</td>
</tr>
<tr>
<td>Phone:</td>
<td>__________</td>
<td></td>
<td>Fax:</td>
<td>__________</td>
<td>E-Mail:</td>
<td>________</td>
</tr>
</tbody>
</table>

If this is your first time submitting to ParaGard PAP, you must submit a copy of your State License.  
State License Number: __________  
A ParaGard unit will be shipped directly to the healthcare professional’s office address above. A signature is required at time of delivery.

Office hours: __________  
Rx: __________  
Product: ParaGard® T 380A IUD

HEALTHCARE PROFESSIONAL’S VERIFICATION AND SIGNATURE

I represent that the information contained in this application is complete and accurate to the best of my knowledge. To the best of my knowledge, this patient does not have medical insurance (including Medicare, Medicaid or other public programs), which covers ParaGard either in whole or in part, and the patient meets the income criteria required to qualify for this Patient Assistance Program. No claim may be made to any third party payer (including government payers) for payment of the ParaGard unit provided by this Patient Assistance Program. The ParaGard received for this patient may not be sold or traded, may not be returned for credit, and is not a sample. I understand that the ParaGard Patient Assistance Program has the right to modify or discontinue this program and its eligibility requirements, or to terminate assistance, at any time and without prior notice.

Please indicate that you agree to these terms by signing below. Your signature confirms that there is a need for this patient’s prescription for ParaGard®.

HCP’s Original Signature: __________  
Date: (mm/dd/yyyy) / / / __________

Duramed Pharmaceuticals, Inc. reserves the right to limit enrollment of patients to the ParaGard Patient Assistance Program at any time.

ParaGard® is a registered trademark of Duramed Pharmaceuticals, Inc.  
PPAPQAF October 2008
Patient Authorization to Disclose Protected Health Information

To the Patient: I understand that during the course of my participation in the ParaGard Patient Assistance Program, that personal identifying information provided will be provided to Duramed Pharmaceuticals, Inc. its affiliated companies and subcontractors on a need to know basis for purposes of administering the program. I understand this information may constitute Protected Health Information (PHI) under the privacy rules of the Health Insurance Portability and Accountability Act (HIPAA).

Authorization Statement

I, (Patient’s Name) _____________________, authorize my prescribing healthcare professional, (HCP’s Name) _____________________, to disclose any personal identifying information to Duramed Pharmaceuticals, Inc., its affiliated companies and subcontractors on a need to know basis for purposes of administering the program for the duration of my participation in the program. I understand that Duramed and its affiliated companies and subcontractors value my privacy. As such, Duramed and its affiliated companies and subcontractors will take reasonable and appropriate measures to protect the information provided by me from inappropriate disclosure and will comply with all applicable state and federal privacy laws.

I further understand that this authorization permits Duramed Pharmaceuticals, Inc., its affiliates and subcontractors to share my personally identifiable information with individuals or entities who are not bound ethically or by any privacy laws and that once in their possession, my personally identifiable information could be used or re-disclosed for any purpose.

I understand that I may revoke this authorization, in writing, at any time by addressing such revocation to my prescribing healthcare professional and/or caregiver and that only a written revocation addressed to such person will constitute an effective withdrawal of my authorization.

Required Signature

_________________________________________________________  _____________________
Signature of patient or legal representative   Date

If signed by patient’s legal representative, complete the following:

Print name of legal representative: _________________________________

Describe representative’s authority to act for patient: _________________________________

Important:

To the Patient:  Once you have completed and signed this authorization form, please give it to your healthcare professional. **Do not send it to the ParaGard Patient Assistance Program.**

To the Healthcare Professional:  Retain the original copy of the Patient Authorization to Disclose Protected Health Information for your records. Please return a copy of this signed form along with the completed Qualification application form to the ParaGard Patient Assistance Program, 250 Phillips Blvd, Ste 250, Ewing, NJ 08618, or fax to 1-800-685-2577.
Theoretically, ParaGard® can exacerbate Wilson’s disease, a rare genetic disease affecting copper excretion. Spontaneous migration has also been reported. If perforation does occur, removal may be followed by pregnancy loss.

Removal may be followed by pregnancy loss.

ParaGard® is not indicated before menarche. Safety and efficacy have been established in women over 16 years old.