MYLAN EMSAM® Transdermal System PATIENT ASSISTANCE PROGRAM ("MEPAP")

781 Chestnut Ridge Road / Morgantown, WV 26505 / Phone: 800.395.3376 / Fax: 304.554.4713

Mylan
Seeing is believing

Please print clearly in blue or black ink

(SECTION 1) PATIENT INFORMATION TO BE COMPLETED BY PATIENT OR LEGAL REPRESENTATIVE

First Name:	MI:	Last Name:	Date of Birth:

Mailing Address:	Apt #:

City:	State:	Zip Code:

Social Security Number:	Gender Male/Female:	Preferred Daytime Telephone:
		( )

(SECTION 2) PATIENT ELIGIBILITY INFORMATION

ATTACH PROOF OF ANNUAL HOUSEHOLD INCOME & LACK OF INSURANCE VERIFICATION (REQUIRED)

GROSS ANNUAL HOUSEHOLD INCOME (Including all Income, Wages, Social Security, Pension, Disability, Unemployment Benefits, Financial Assistance, etc)

Does the patient meet the income requirements of 200% of the current Federal Poverty Guidelines? Yes ☐ No ☐

If "No", the patient is not eligible.

Number of people in household: _____ **$**_____ **Monthly** **$**_____ **Annual**

LACK OF PRESCRIPTION DRUG COVERAGE (Approved documents include:Termination letter, Denial Letter, or Written Statement from Physician)

Is the patient currently enrolled in a Medicare Part D Prescription Drug Plan? Yes ☐ No ☐

Does the patient have any public or private prescription insurance coverage, including Medicaid, TriCare, or a qualified exchange plan offered on a health care exchange? Yes ☐ No ☐

Is the patient a U.S. Citizen or legal resident? Yes ☐ No ☐

(SECTION 3) PATIENT AUTHORIZATION FOR INFORMATION USE AND DISCLOSURE

I request and authorize my health care providers and health insurers to disclose to Mylan Specialty and its affiliated companies (collectively, "Mylan") my personal health information ("PHI") so that Mylan may use the information to determine my eligibility for insurance coverage for Mylan Emsam and to administer my participation in the Mylan Emsam Patient Assistance Program ("MEPAP"). I understand that once disclosed pursuant to this Authorization, my PHI may no longer be protected by federal law and could be re-disclosed to others, but I also understand that Mylan intends to safeguard my PHI and to use and disclose it only for the purposes described herein. I understand that I do not need to sign this Authorization in order to receive health care treatment or insurance benefits, and that I may cancel this Authorization at any time by sending a written notice of cancellation by mail to MEPAP Opt-Out Administrator, 781 Chestnut Ridge Road, Morgantown, WV 26505, or by fax to 1-304-554-4713. If I do not cancel it, this Authorization will remain in effect for one year from the date of my signature below. I understand that I have a right to receive a copy of this Authorization when it is signed.

_____	_____	_____
[Name of Patient]	[Signature]	[Date]
_____	_____	_____
[Name of Legal Representative]	[Signature]	[Date]

If signed by Representative, describe the nature of relationship with patient:

(SECTION 4) PATIENT CERTIFICATION

I certify that the information detailed on this form is indeed complete and accurate. I attest that I have no prescription insurance coverage including under Medicaid, Medicare, TriCare, any health care exchange program, or any other public or private program, I have insufficient financial resources to afford the prescribed medication, and I meet the MEPAP income eligibility criteria. Additionally, I agree that at any time during my enrollment, the MEPAP may request additional documentation to authenticate the statements made on my application. I understand and acknowledge that MEPAP assistance may be temporary and that this program may be changed or discontinued at any time without notice.

_____	_____	_____
[Name of Patient]	[Signature]	[Date]
_____	_____	_____
[Name of Legal Representative]	[Signature]	[Date]

If signed by Representative, describe the nature of relationship with patient:

(SECTION 5) PHYSICIAN INFORMATION

TO BE COMPLETED BY THE PRESCRIBING PRACTITIONER

First Name:	Last Name:	Professional Designation:
2118		
State License #:		
Facility Name:		
Shipping Address:		
City:	**State:**	**Zip Code:**
Contact Name:	**Telephone Number:** ( )	**Fax Number:** ( )

(SECTION 6) PRESCRIPTION INFORMATION AND PHYSICIAN CERTIFICATION

PLEASE ATTACH A COPY OF THE PATIENT'S PRESCRIPTION

EMSAM® Transdermal System	**6 mg**	☐	**Quantity per day:**
EMSAM® Transdermal System	**9 mg**	☐	**Quantity per day:**
EMSAM® Transdermal System	**12 mg**	☐	**Quantity per day:**

I certify that all information I have provided about this patient is complete and accurate, and I understand that the MEPAP and/or its agents are relying on this information to determine patient eligibility. To the best of my knowledge, the patient has no prescription insurance coverage including under Medicaid, Medicare, TriCare, any health care exchange programs, or any other public or private program, and the patient has insufficient financial resources and meets the MEPAP income eligibility criteria. I acknowledge and agree not to submit an insurance claim or other claim for payment to any third-party payor (private or government) for the free product provided by the MEPAP. I understand that MEPAP reserves the right to modify or terminate this program at any time. My signature certifies that the medication received from MEPAP will not be resold or offered for sale, trade or barter, and will not be returned for credit. I further certify that no reimbursement of the cost of product has been/will be accepted by me for any treatments where product has been/will be provided free-of-charge by MEPAP, including any product that has already been administered to the patient and for which replacement product will be provided to me. I understand MEPAP reserves the right to recall or discontinue product at any time without notice.

Physician Signature: _____ **Date:** _____

(SECTION 7) FINAL CHECKLIST

Before mailing this application, please take a quick moment to make sure:

- ☐ **Patient or Legal Representative has completed and signed the application (Sections 1-4)**
- ☐ **Physician has completed and signed the Physician Information and Prescription Information and Physician Certification sections (Sections 5&6)**
- ☐ **A copy of the patient's prescription has been attached (Section 6)**
- ☐ **Copies verifying current financial status have been attached (Please do not send original documents)**
- ☐ **Copies verifying lack of prescription drug coverage have been attached (Please do not send original documents)**