arbor® PHARMACEUTICALS, LLC

GLIADEL® WAFER (carmustine implant)

ARBOR ASSISTANCE PROGRAM

Telephone: (866)-516-4950, Option 4 ■ Fax: (866) 448-1960
Email: reimbursement@arborpharma.com
Hours: Monday – Friday, 8:00 AM to 5:00 PM CST

GLIADEL® WAFER PATIENT ASSISTANCE PROGRAM APPLICATION

Section 1: PATIENT INFORMATION

U.S. Resident: ❒ Yes ❒ No Social Security #: Phone: Email:

Patient Name: Date of Birth: ___/___/_____ Gender: M ❒ F ❒

Address: City: State: Zip:

Section 2: PRESCRIPTION & PHYSICIAN CERTIFICATION

GLIADEL® WAFER QTY: 1 Box Known Allergies? ❒ No ❒ Yes, please specify:

Other Medications Currently Taking:

Physician's Signature (required for processing): _____ Date: _____

I certify that the information provided in this application is complete and accurate and that the product ordered hereunder is medically indicated for this patient. I further certify that the product shipped to me pursuant to this application will be provided to the above-named patient only, for his or her treatment, and will not be sold or otherwise distributed and that no patient or third party shall be charged for such product. Additionally, no units of product will be submitted for Medicare, Medicaid, or any public or private third party reimbursement, or returned for credit. I understand eligibility under this Program is subject to ARBOR'S approval and the patient's continuing compliance with all eligibility requirements, as set by ARBOR from time to time. I agree to allow ARBOR authorized agents Truax Patient Services to review the medical and financial records for this patient at any time for the purposes of verifying the patient's eligibility status for the Program and the patient's receipt of any product(s) provided to him or her through the Program.

Section 3: PHYSICIAN INFORMATION

Physician Name: NPI #: State License #: DEA #

Practice Name: Tax ID #

Address: City: State: Zip:

Office Contact: Phone: Fax: Email:

Section 4: SHIPPING INFORMATION (GLIADEL® WAFER typically ships 1 – 3 business days following PAP approval)

Ship to Medical Facility Name: State License #: DEA #

Address: City: State: Zip:

Contact Name: Phone: Fax: Email:

Section 5: INSURANCE INFORMATION

Does the applicant have insurance? ❒ Yes ❒ No

An insured individual, whether or not covered for a particular item or service, is not eligible for participation in this program

Section 6: FINANCIAL INFORMATION (financial documentation may be required for the patient to receive PAP assistance)

Total Household Gross Monthly Income $_____

Included but not limited to Salary, Wages, Pension, Retirement, Social Security, Social Security Disability, Alimony, Child Support, Unemployment and Worker's Comp.

Total Current Year to Date Out of Pocket Prescription Costs $_____

Provide the amount the patient has spent year to date (January–current month).

Number of household members dependent on income stated above (including applicant): _1 _2 _3 _4 _5 _6 _7 _8 (check one) # Over 8: ___

Section 7: PATIENT DECLARATION

Informed Consent and Authorization for Use and Disclosure of Health Information for Patient Assistance Program

I certify that I do not have the ability to pay for the medication requested by my physician in Section 2 of this application and all information provided in Sections 1, 5 & 6 is correct. I understand that completing this form does not ensure that I will qualify for the GLIADEL® WAFER Patient Assistance Program ("Program"). I represent that the information provided in this qualification form is complete and accurate. I agree to notify and shall be responsible for notifying the Program Administrator for the Program if I obtain coverage through another source or if I no longer meet the income criteria for the Program. **I understand that personal identifying information provided on this form will be available to Program Administrator and its agents for the purpose of administering the Program.** I understand that **Program Administrator** reserves the right at any time and without notice to me to modify and/or discontinue any or all of the **Program**, including modification of eligibility criteria and immediate termination of assistance provided by the **Program**. I understand that I have a right to obtain a copy of the information my health care providers have provided to **Program Administrator** upon request to **Program Administrator**. I understand that I may decline to sign this form and decline being considered for the Program. I understand that signing this form does not affect the way my health care providers or insurer will provide me with their respective services.

Signature of Patient or Legal Representative: _____

Printed Name of Patient or Legal Representative: _____

(If signed by representative, explain authority to act on behalf of patient): _____

Relationship to Patient: _____ **Date:** _____

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GLIADEL® WAFER PATIENT ASSISTANCE PROGRAM
Effective Date March 1, 2020

Dear Applicant:

Thank you for your interest in the GLIADEL® WAFER Patient Assistance Program (PAP). Enclosed you will find the application for assistance for GLIADEL® WAFER. It is important that you complete all requested information and sign where indicated. Incomplete or incorrect applications will delay the application process.

PATIENT REQUIREMENTS:

- ✓ Complete all fields in Sections 1, 5, 6 & 7 on the Patient Assistance Program Application
- ✓ **Provide upon request** a copy of the ANNUAL household income (Federal tax return (1040), social security income (SSA 1099), pensions, interest, retirement, child support, etc.). See income requirements on the next page.

LICENSED PRACTITIONER REQUIREMENTS:

- ✓ Complete all fields in Sections 2, 3 & 4 on the Patient Assistance Program Application
- ✓ **Attach** a photocopy of the prescription written for GLIADEL® WAFER listed in section 2

SUBMIT COMPLETED APPLICATION BY:

FAX: (866) 448-1960
OR
E-MAIL: reimbursement@arborpharma.com

APPLICATION PROCESSING:

While every effort will be made to expedite the application, processing and delivery of medication to the licensed medical treatment facility named on the application form (Section 4) may take up to 5 to 10 days. Upon approval, the applicant, licensed practitioner and medical treatment facility representative will be notified by email and phone. If the applicant is denied, the licensed practitioner, applicant and medical treatment facility representative will be notified by phone. Incomplete applications will delay the processing of the form and will result in the applicant or licensed practitioner being contacted with instructions for completion.

If you have questions or need further assistance, please call 1-866-516-4950, Option 4 between 8:00 AM to 5:00 PM CST, Monday through Friday.

Sincerely,
Arbor Pharmaceuticals, LLC.
GLIADEL® WAFER Patient Assistance Program

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INCOME ELIGIBILITY GUIDELINES

Eligibility is based on the following requirements:

- You must not be a beneficiary of any private, public, or government funded insurance program. For avoidance of doubt, an insured individual, whether or not covered for a particular item or service, is **not** eligible for participation in the program.
- You must be a citizen of the United States or its Territories.
- You must be an inpatient currently under the care of a physician.
- Your income must be less than or equal to 200% of the Federal Poverty Guideline for the size of your household (see chart below).

<Insert Current Poverty Guideline Chart>

Federal Poverty Level Guidelines <Insert Year>