AZURITY ASSISTANCE PROGRAM
Telephone: (877) 438-9759 ■ Fax: (877) 619-6574
Email: AAP@truaxpatientservices.com
Hours: Monday – Friday 8:00 AM – 5:00 PM CST

GLIADEL® WAFER PATIENT ASSISTANCE PROGRAM
Effective Date November 1, 2019

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. Please note that this program is managed by Azurity Pharmaceuticals, Inc.

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.
- ✓ **Attach** a photocopy of your Medicare Part A Denial Letter *(if applicable)*
- ✓ **Attach** a photocopy of your Medicaid Denial *(if applicable)*
- ✓ **Attach** a photocopy or your Insurance Denial *(if applicable)*

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: (877) 619-6574
OR
E-MAIL: AAP@truaxpatientservices.com

Please allow 1 to 2 weeks for application processing and delivery of medication to the licensed medical treatment facility named on the application form. 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 result in contacting the applicant or licensed practitioner with instructions for completion.

If you have questions or need further assistance, please call (877) 438-9759 between 8:00 AM and 5:00 PM CST, Monday through Friday.

Sincerely,
Azurity Pharmaceuticals, Inc.
GLIADEL® WAFER Patient Assistance Program

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INCOME ELIGIBILITY GUIDELINES

Eligibility is based on the following requirements:

- You must not be covered by any private, public, government or Medicare Part A health insurance programs.
- 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).

Household Size	200% of FPL Per Year		
Persons in Family of Household	48 Contiguous States and D.C.	Alaska	Hawaii
1	$29,160	$36,420	$33,540
2	$39,440	$49,280	$45,360
3	$49,720	$62,140	$57,180
4	$60,000	$75,000	$69,000
5	$70,280	$87,860	$80,820
6	$80,560	$100,720	$92,640
7	$90,840	$113,580	$104,460
8	$101,120	$126,440	$116,280
9	$111,400	$139,300	$128,100
10	$121,680	$152,160	$139,920
11	$131,960	$165,020	$151,740
12	$142,240	$177,880	$163,560
13	$152,520	$190,740	$175,380
14	$162,800	$203,600	$187,200

2023 Federal Poverty Level Guidelines

azurity pharmaceuticals

GLIADEL® WAFER (carmustine implant)

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GLIADEL® WAFER PATIENT ASSISTANCE SUPPORT FORM

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 AZURITY'S approval and the patient's continuing compliance with all eligibility requirements, as set by AZURITY from time to time. I agree to allow AZURITY, or its authorized agent(s), to review the medical, financial and insurance 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 (attach a copy of insurance cards if available)

Does the applicant have insurance? ❒ Yes ❒ No If yes, complete the table below (include all insurance policies)

Insurance Information	Check One	Policy Number	Phone Number
Private Insurance Coverage	❒ Yes ❒ No		
Medicaid	❒ Yes ❒ No		
Medicare Part A	❒ Yes ❒ No		
Other Insurance	❒ Yes ❒ No		

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 authorize my healthcare provider to disclose medical information and related information to AZURITY and its affiliated companies and subcontractors (collectively "Company"), Truax Patient Services (the "Program Administrator") and AmeriCares ("AmeriCares"), and I authorize the Company to obtain and disclose information as deemed necessary to verify the accuracy and completeness of this application and to provide services available through the Program. I also authorize Company to release medical information and related information to the Centers for Medicare and Medicaid Services ("CMS") for purposes of administering the Program. I understand that personal identifying information provided on this form will be available to Company and its agents for the purpose of administering the Program.** I understand that Company reserves the right at any time and without notice to me to modify and/or discontinue any or all the Program, including modification of eligibility criteria and immediate termination of assistance provided by the Program. If I decide to terminate my authorization for my health care provider and my insurers to disclose my information to Company, I shall notify Company by Fax: (877) 619-6574, ATTN: GLIADEL® WAFER Patient Assistance Program, that I no longer provide such authorization and I understand that the termination of the Program shall be effective upon Company's receipt of such notification. I understand that I have a right to obtain a copy of the information my health care providers or insurers have provided to Company upon request to Company. 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:** _____

CONFIDENTIAL