ZELNORM™ PATIENT ASSISTANCE PROGRAM ENROLLMENT FORM

PATIENT INFORMATION

Patient Name: _____ Sex: ☐ Male ☐ Female

DOB: ____/____/____ (Date of Birth: MM/DD/YYYY)

☐ HOME ☐ CELL ☐ WORK Phone: _____

☐ HOME ☐ CELL ☐ WORK Phone: _____

Email: _____

Address: _____ Address 2: _____

City: _____ State: _____ Zip: _____

Do you personally reside in the US or Puerto Rico? ☐ YES ☐ NO

Do you have a prescription for ZELNORM? ☐ YES ☐ NO

PATIENT INSURANCE INFORMATION

Please check all that apply:

☐ Insured with no Rx Coverage ☐ Commercial/Private Insurance

☐ Uninsured ☐ Healthcare Marketplace Plan

Medicare: ☐ Part A ☐ Part B ☐ Part D ☐ Advantage

Medicaid: ☐ Actively Enrolled ☐ Applied/Pending ☐ Denied (provide letter) ☐ Never Applied

Medical Insurance Company	Prescription Drug Plan Name (if different than medical insurance)	Other ☐ Secondary/Supplemental ☐ Veterans Affairs Benefits ☐ State Pharmaceutical Assistance Program
Name of Insured (cardholder)		
Policy # / Group #	Policy # / Group #	Policy Name
Plan Phone	Name of Insured (cardholder)	Policy Phone
Member ID #	Plan Phone	Policy #

Please copy front and back of medical insurance and prescription drug plan cards and include with fax or email.

HEALTHCARE PROFESSIONAL/FACILITY INFORMATION

Physician Name: _____

Facility Name: _____

Address: _____ Address 2: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

PATIENT FINANCIAL INFORMATION (Required for Financial Assistance)

Patient may be required to verify their gross annual household income. Income must reflect amount for entire household.

Please indicate your household size based on IRS Form 1040 or 1040 EZ (number of persons dependent upon total household income): _____

Please indicate your household's Adjusted Gross Income as it appears on the most recent year's federal tax return: $ _____

Please attach a copy of the most recent year's federal tax return (IRS Form 1040 or 1040 EZ), the W2 form(s) that document your household income, or submit an IRS Form 4506-T. Please note that household income also includes alimony, child support, Social Security, pension or retirement payments, unemployment benefits, workers' compensation, and/or disability payments your receive.

ACKNOWLEDGEMENT OF TERMS AND CONDITIONS

I verify that I meet the eligibility requirements (as outlined on https://myzelnormsavings.com) and that the information provided on this application is complete and accurate. I understand that any assistance provided under the ZELNORM Patient Assistance Program will terminate if Alfasigma USA, Inc. becomes aware of any false or inaccurate information or if ZELNORM is no longer prescribed for me. I understand that completing this application does not ensure that I will qualify for the ZELNORM Patient Assistance Program. I agree that I will notify Alfasigma USA, Inc. if my financial information or insurance coverage changes. I certify that no part of the cost of ZELNORM is or will be covered or reimbursed by a federal or state healthcare program, including but not limited to Medicaid and Medicare. I agree that I will not submit any claims to insurance for reimbursement for my prescriptions covered under the ZELNORM Patient Assistance Program. I understand and agree that any assistance I receive under the Patient Assistance Program will not count towards my true-out-of-pocket costs (TrOOP) as defined under the Medicare Modernization Act.

I understand that the ZELNORM Patient Assistance Program may request documentation to verify financial or insurance information and that any assistance in the form of free medication is contingent upon meeting the program eligibility criteria. I also understand that Alfasigma USA, Inc. reserves the right at any time and without notice, to modify the application form; modify or discontinue this program and its eligibility criteria; or terminate assistance.

I authorize the ZELNORM Patient Assistance Program to obtain information from my prescribing physician, insurance company, and other sources as deemed necessary to ensure the accuracy and completeness of this application.

I authorize my healthcare providers and health plans to disclose personal and medical information about me to Alfasigma USA, Inc. and its agents and contractors, and I authorize Alfasigma USA, Inc. to use, share and disclose this information to third parties to: 1) establish my benefit eligibility; 2) provide support services, including facilitating the provision of Alfasigma USA, Inc. medication to me; and 3) contact me to evaluate therapy and the effectiveness of the program.

This private and confidential program provides product free of charge to eligible individuals, primarily the uninsured who, without our assistance, could not afford ZELNORM. A single application for assistance may allow for up to 6 months of product free of charge to eligible individuals and an individual may reapply every 6 months and as many times as needed. If you have been prescribed ZELNORM, you may be eligible for the program if the following conditions apply:

- You do not have insurance or other coverage for your prescription medicine. Some examples of other insurance coverage include private insurance, HMOs, Medicaid, Medicare, state pharmacy assistance programs, veterans assistance, or any other social service agency support.
- You cannot afford to pay for your medicine.
- Patients enrolled in or that participate in Medicare Part D, Medicare, Medicaid, MediGap, VA, DOD or Tricare, or any other government run or government sponsored health care program with a pharmacy benefit are not eligible to participate in the ZELNORM Patient Assistance Program.

PATIENT SIGNATURE: _____ DATE: _____

Alfasigma USA, Inc. understands that your privacy is important. By providing your name, address, and other requested information, you are giving Alfasigma USA, Inc., and other parties working with us, permission to communicate with you about ZELNORM or other products, services, and offers from Alfasigma USA, Inc.

Alfasigma USA, Inc. holds the highest respect for its customers and guarantees our firm commitment to your privacy. We do not sell any of the information provided by you to any other institutions.

For any questions and concerns about the program, please call a customer service representative at: 1-267-214-9644

The completed application can be submitted by Fax, Email or by Mail to:

ZELNORM Patient Assistance
2325 Heritage Center Drive,
Furlong, PA 18925

Fax: 1-908-926-2652
Email: ZelnormPAP@myzelnormsavings.com

To report an adverse event to ZELNORM, please contact Alfasigma USA, Inc. at 1-855-697-9232.