Triptodur®
(triptorelin)
for extended release injectable suspension

TRIPTODUR CARE℠

PATIENT ASSISTANCE PROGRAM

Customer Service: (833) 401-2273 | **Fax completed form to:** (855) 246-3986
Visit us: www.Triptodur.com

PATIENT ASSISTANCE PROGRAM FORM

*Indicates required field

Please attach insurance card image.

PATIENT INFORMATION

*Patient Name (Last, First):

*Date of Birth: *Gender: M ☐ F ☐

*Address:

*City: *State: *Zip:

*Caregiver Name (Last, First):

Caregiver Email:

*Caregiver Phone: Secondary Number:

PHARMACY INSURANCE INFORMATION

*Insurance Name: Pharmacy Help Desk #:

Policyholder Name: *Relationship to Patient:

*Member ID #: *Group ID #:

*Rx BIN #: *PCN #:

MEDICAL INSURANCE INFORMATION

*Primary Insurance: *Phone:

*Member ID: *Group ID:

Secondary Insurance: Phone:

Member ID: Group ID:

Prescriber: ☐ In Network ☐ Out of Network

DIAGNOSIS INFORMATION

Drug: **TRIPTODUR (triptorelin) 22.5 mg** Date:

Quantity: **1 Kit (22.5mg/2mL Injectable)** Refills:

Directions: **Inject 22.5mg intra-muscularly every 24 weeks**

ICD-10/Diagnosis Code: ☐ E30.1 ☐ E22.8 ☐ Other:

PRESCRIBER INFORMATION

*Prescriber Name (Last, First):

*NPI:

*Prescriber Phone: *Fax:

*Address:

*City: *State: *Zip:

Email:

*Tax ID: *Medicaid Provider ID:

PRESCRIBER OFFICE CONTACT INFORMATION

*Office Contact Name (Last, First):

*Email: *Phone:

Site of care: ☐ Hospital/Outpatient ☐ Ambulatory/Surgical Center ☐ Physician's Office ☐ Other:

Do you have the patient's HIPAA consent on file authorizing the release of the patient's identification and insurance information to Azurity Pharmaceuticals, Inc. and their agents and representatives for benefit verification and patient assistance services?
☐ YES ☐ NO (Confirmation of written patient HIPAA consent is required for benefits verification & patient assistance services)
By signing this form I hereby confirm that I have properly obtained the required consent and authorization (if needed) that are required under Federal HIPAA and other State and Federal privacy laws, to release and share certain protected health information to the Triptodur Care PAP Program managed by its contracted third party ("the PAP"). I further certify that the information provided is complete and accurate to the best of my knowledge.
I verify that I am a practicing healthcare provider, authorized to request, prescribe and receive prescription medications at the address identified herein. I will notify the PAP if any changes occur to my status in this regard. I further verify that I understand the PAP program may make product available to eligible patients (as determined by the PAP), and ship such product to me designated for a specific approved patient's use. I further verify that I am prescribing the medication identified and ordered for my patient through the PAP and will only dispense the product received for the specific patient identified and enrolled in the PAP. I may not dispense or use product provided by the PAP for any other purpose.
I further verify that I shall not bill, sell, seek reimbursement from the government or any third party or file any claim for the drug product provided under the PAP. I also acknowledge that my patient's approval and participation in the PAP was not in exchange for any promise or reward or other explicit or implicit agreement with Azurity for or relating to past or future use, ordering, prescribing, recommending or referring of any Azurity products.
Prescriber Return Clause
I confirm and agree that if the patient does not show up for the PAP medication or is otherwise unavailable to receive the product provided by the PAP within 30 days from receiving the PAP drug product, I must contact the PAP and arrange for the return of the product. I will call (833) 401-2273 to obtain assistance and instructions on PAP returns.

***Prescriber's Signature** ______________________ ***Date of Signature** ______________

Please see Important Safety Information available at **www.Triptodur.com** and the accompanying full **Prescribing Information**.

CONTINUE ➡

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FOR OHIO LICENSED HEALTHCARE PRACTITIONERS ONLY

Please print/type your Terminal Distributor of Dangerous Drug (TDDD) license number (if applicable):

Are you exempt from TDDD licensure? ☐ YES ☐ NO

By checking "Yes," you attest that you meet one of the licensing exemptions under ORC 4729.541. Exemptions include but are not limited to: (1) prescribers who are sole proprietors; (2) business practices with a sole shareholder (per Ohio law, group practices with multiple shareholders are not exempt); and (3) dentists licensed by the Ohio Dental Board. Please visit the Ohio State Board of Pharmacy website for additional information. By checking "No," you attest that you have provided a valid TDDD license number above. Your signature serves as attestation and that you have the appropriate TDDD licensure or qualify under an exemption.

PATIENT ASSISTANCE PROGRAM

Total number of people in household: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ Other: Annual Household income $:

Representative/ Organization Name | Relationship | Phone #

AUTHORIZATION FOR DISCLOSURE OF INFORMATION

This "Authorization" is hereby provided for the purpose of providing permission for the use and disclosure of my protected health information, including but not limited to my name, medication be treated for, application into the Triptodur Care PAP Program, insurance and financial information and other relevant information. I hereby request and authorize my healthcare providers and insurers to disclose any healthcare, treatment, insurance and other information that pertains to my medication to Azurity Pharmaceuticals, Inc. and its third party vendors ("Azurity") for the purpose of (a) processing my application for access to the Triptodur Care Patient Assistance Program ("PAP"); determining my eligibility in the PAP; (c) determining my ongoing eligibility status and future transfers, withdrawals or cancellations, including case reviews, audits, assessments and other verification procedures. Upon receipt of my healthcare information, I hereby authorize Azurity to disclose such information to my healthcare providers and insurers as necessary to determine my eligibility in the PAP and if approved, to notify of enrollment in the PAP. I understand that my future treatment, prescriptions and medical care from healthcare providers and insurers are NOT contingent upon signing this Authorization and that I am not required to sign this Authorization. However, I understand that if I do not sign this Authorization, I will not be eligible for the PAP. I further understand that I may cancel this Authorization by faxing a letter to (855) 246-3986. Upon providing such notification, Azurity may not further disclose my health information and I will not be eligible for the PAP as of the notification date.
This Authorization shall be valid for 10 years from the date set forth below, unless required to be shorter by State Law. Upon signing this Authorization my health information will no longer be protected under HIPAA and is subject to re-disclosure.

PATIENT ATTESTATION FOR MEDICARE OR MEDICAID PRESCRIPTION DRUG PLAN

If I am a member of a Medicare Prescription Drug Plan, I understand that I may be eligible if I am uninsured for the Triptodur Care PAP, as solely determined by Azurity.
If I am eligible for a Medicaid Prescription Drug Plan, but that plan does not cover the Azurity drug products, I may be eligible for the PAP if:

- I agree I will file no claim with any government or commercial insurer for the drug product provided to me under the PAP (e.g. Medicare, Medicaid, Puerto Rico's Government Health Plan Mi Salud, or any Commercial Insurer).
    - I obtain confirmation from Medicaid that it will not cover the Azurity drug product. (If the Medicaid Program covers a portion of your cost, you will not be eligible for the PAP).
    - If eligible, I have applied for Puerto Rico's Government Health Plan Mi Salud and have been denied.
    - I agree to send notification to my Medicaid provider that I have received free product under the Triptodur Care PAP in order to ensure that no payment for the product is made under the Medicaid Plan.
- I further verify that if my insurance or financial information changes in any material respect (e.g. change in employment, insurance/medical expenses or total household number), I will immediately notify Azurity.

CERTIFICATION FOR PATIENT ASSISTANCE

Print Patient Name | If You Are Signing This Authorization As A Personal Representative Of The Person To Receive Triptodur®, Please State Your Relationship (E.g., "Mother," "Father," "Legal Guardian")

Print Name Of Caregiver/Legal Representative | Relationship To Patient

Signature | Date

Please see Important Safety Information available at **www.Triptodur.com** and the accompanying full **Prescribing Information**.

CONTINUE ➡

PATIENT ASSISTANCE PROGRAM

TERMS AND CONDITIONS

- Patient and caregiver must be a United States (U.S) citizen or resident and must physically reside in the U.S or U.S territory
- Patient has been prescribed Triptodur for an on-label, FDA-approved indication.
- Prescriber must complete and submit a PAP enrollment form for every patient.
- Patients whose health insurance plan or employer requires them to go through a third-party Alternative Funding Program (AFP) and apply to the PAP as a condition of, requirement for, or prerequisite to coverage of Triptodur will not be eligible for assistance from this program.
- Income criteria that demonstrate qualifying financial needs and proof of income documentation.
- Medical Expenses: Acceptable medical expenses submitted to the program should contain the amount and date of the transaction.

Azurity reserves the right to cancel or modify the program at any time.

DOCUMENTATION REQUIREMENTS

- Please complete all the sections of this form
- Please submit a copy of Medicare card or letter of Medicaid and/or Social Security denial, if applicable
- Please have the caregiver sign this form for the Triptodur Care Patient Assistance Program
- Proof of income is required: Submit an acceptable form of income documentation (If not required to file a US income tax return, IRS Form 4506-T may be required)
  - Copy of W-2 (from all employers) or most recently filed US Income Tax (IRS Form 1040, 1040A, 1040EZ, 1040NR, or 1040PR)

    or
  - Copy of most recent pay stub plus most recent US Income Tax Return,

    or
  - Copy of most recent IRS Form-1099 plus most recent US Income Tax Return,

    or
  - Copy of most recent SSA-1099 plus most recent US Income Tax Return

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