



Please find enclosed an application for the Eurand Pharmaceuticals, Inc. Uninsured Patient Assistance Program. There is a section to be completed by the patient/parent and a section which must be completed by the prescribing physician. If the patient/family qualify based on financial need, Eurand will provide up to a ninety day supply of **Zenpep® (pancrelipase) Delayed Release Capsules at no cost.**

If the patient has an ongoing medical need and requires additional free shipments of medication, the 'Continuing Support UPAP Application must be completed and signed by patient/parent and prescribing physician each 90 days. The patient or physician can request this form, as needed through the Zenpep Support Center at 1- 800-ZENPEP1. Both the patient/parent's signature and the prescribing physician's signature are required on the application form.

For Physicians:

The Prescription Drug Marketing Act of 1987 requires the Eurand Pharmaceuticals, Inc. Uninsured Patient Assistance Program to verify that the prescribing physician is currently licensed. **Please enclose a photocopy of your current medical license with the completed application form. The license number and expiration date must be clearly legible.** This copy of your current medical license is for the Eurand Pharmaceuticals, Inc. Uninsured Patient Assistance Program's files only and will remain confidential. We will be unable to process your request if the above documentation is not provided.

Please use one Eurand Pharmaceuticals, Inc. Uninsured Patient Assistance Program application per patient. You can request additional application forms from the Eurand Pharmaceuticals, Inc. Uninsured Patient Assistance Program at the telephone number listed below.

For more information about Eurand Pharmaceuticals, Inc's products, you can visit our web site at: www.eurand.com.

Please refer to the instruction sheet enclosed for completing the Eurand Pharmaceuticals, Inc. Uninsured Patient Assistance Program application forms. If you have any questions, you may contact the Eurand Pharmaceuticals, Inc. Uninsured Patient Assistance Program at 1-888-ZENPEP1 (1-888-936-7371), Option 2.

Sincerely,

Program Administrator
Eurand Pharmaceuticals, Inc. Uninsured Patient Assistance Program



EURAND PHARMACEUTICALS, INC.
UNINSURED PATIENT ASSISTANCE PROGRAM CHECKLIST

The following 4 items **MUST** be faxed or mailed for Eurand Pharmaceuticals, Inc. Uninsured Patient Assistance Program requests to be processed:

- Authorization For Use Or Disclosure Form
- Application Form
- Photocopy of physician's DEA license with expiration date clearly indicated
- Patient Documentation:
 - Proof of Residency (Copy of Birth Certificate or Passport, or Visa)
 - Proof of Income (Two (2) Consecutive Pay Stubs or W2 or 1040's (tax returns) or Social Security Letter, Disability Benefit Summary or Unemployment Benefit Letter – All income earners in household.)
 -

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION FORM

(To be filled out by patient)

- Form requires patient signature.
- Please fax to 888-832-5335 ATTN: Eurand Pharmaceuticals, Inc. Uninsured Patient Assistance Program Department or mail completed form with the corresponding Application Form to the Eurand Pharmaceuticals, Inc. Uninsured Patient Assistance Program at the following address:

Eurand Pharmaceuticals, Inc. Uninsured Patient Assistance Program
ATTN: CFS
6931 Arlington Blvd.
2nd Floor
Bethesda, MD 20814

- **Important:** Please retain a copy of the forms for patient records.

APPLICATION FORM

(To be filled out by patient and physician)

- Patient completes and signs Authorization For Use or Disclosure of Health Information Form and Patient Section of the Application Form
 - IMPORTANT: Patient must meet all eligibility criteria, per the application, in order to receive uninsured patient assistance from the Eurand Pharmaceuticals, Inc. Uninsured Patient Assistance Program– see check boxes below.
- Physician completes and signs Physician Section of Application Form – no signature stamps accepted.
- Please fax to 888-832-5335 ATTN: EURAND PHARMACEUTICALS, INC. PAP Department or mail completed Authorization Forms to Eurand Pharmaceuticals, Inc. Uninsured Patient Assistance Program at the following address:

Eurand Pharmaceuticals, Inc. Uninsured Patient Assistance Program
ATTN: CFS
6931 Arlington Blvd.
2nd Floor
Bethesda, MD 20814

- **Important:** Please retain a copy of the form for physician/patient records. For assistance, please call 1-888-ZENPEP1 (1-888-936-7371), (Please select option 2)



AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

I authorize the use or disclosure of health information about me as described below.

1. Person(s) or class of persons authorized to use or disclose the information:
I agree to permit the Eurand Pharmaceuticals, Inc. Uninsured Patient Assistance Program and any of its current or future contracted partners or vendors under mutually signed and executed confidentiality agreements to use and disclose health information about me.
2. Person(s) or class of persons authorized to receive the information:
I agree to permit the Eurand Pharmaceuticals, Inc. Uninsured Patient Assistance Program and any of its current or future contracted partners or vendors under mutually signed and executed confidentiality agreements to receive health information about me.
3. Description of information that may be used or disclosed:
All health information related to my application for the Eurand Pharmaceuticals, Inc. Uninsured Patient Assistance Program, and health information in my medical records that is relevant to my application.
4. The Eurand Pharmaceuticals, Inc. Uninsured Patient Assistance Program is authorized to use the information to determine if I qualify for the Eurand Pharmaceuticals, Inc. Uninsured Patient Assistance Program and, if it is determined that I qualify, in providing me with medically indicated medications available from the Eurand Pharmaceuticals, Inc. Uninsured Patient Assistance Program.
5. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations.
6. I understand that I may refuse to sign this authorization. If I do not sign; however, I understand that I will not be able to participate in the Eurand Pharmaceuticals, Inc. Uninsured Patient Assistance Program.
7. I understand that I may revoke this authorization at any time by sending a written request to Eurand Pharmaceuticals, Inc. Uninsured Patient Assistance Program, Attn: CFS, 6931 Arlington Blvd, 2nd floor, Bethesda, MD 20814 Attn: UPAP Department except to the extent that action has been taken in reliance on this authorization.
8. This authorization expires one (1) year from the date that I sign it.

Signature of Patient or Guardian / Patient Representative

Date

Patient Name (please print)

Name of Guardian / Patient Representative (if applicable)

Relationship to Patient



APPLICATION FORM – PATIENT SECTION

Patient Name: _____ Male _____ Female _____ (check one)
Address (P.O. Box not acceptable): _____
City _____ State _____ Zip Code _____ Telephone #: _____
Annual Household Income: _____ # of Members Residing in Household _____
Email: _____ Patient Date of Birth _____

Patient Eligibility: The patient must meet ALL the following Eurand Pharmaceuticals; Inc. Uninsured Patient Assistance Program eligibility requirements (please check all that apply):

- The Patient must be a legal resident of the United States. (Submit proof of U.S. residency – U.S, Birth Certificate, Passport or VISA)
The patient cannot have or qualify for any government prescription coverage for Zenpep™ such as Medicare, Medicaid, Veteran’s Administration or any state and/or local government programs.
The patient has no reimbursement options including qualification for any private insurance coverage such as an HMO or PPO that would enable the patient to receive coverage and/or reimbursement for the prescription drug applied for on this application.
I understand that my/the patient’s annual household/family income will be reviewed to confirm that it does not exceed 200 percent of the federal poverty level, adjusted by family size; refer to policy below. (Proof of household income must be provided.) I affirm that I have provided full and complete information on household/family income for this review.

I certify that I meet all the above eligibility requirements, and that I authorize the Eurand Pharmaceuticals, Inc. Uninsured Patient Assistance Program at its discretion to request my medical/financial records and/or contact me directly to confirm my program eligibility or receipt of drug. I understand that these records and my participation in this program will be held confidential, except as required by law.

Signature of Patient or Guardian / Patient Representative Date

Patient Name (please print)

Name of Guardian / Patient Representative (if applicable) Relationship to Patient



APPLICATION FORM – PHYSICIAN SECTION

Physician Must Complete (please print or type)

Physician Name: _____ Specialty _____

NPI Number: _____ DEA Number: _____

Primary Office Contact: _____ Email: _____

Street Address: _____ Telephone: _____

(P.O. Box not acceptable)

City: _____ State: _____ Zip: _____ Fax: _____

Prescription: Dispense as written:

Patient Name: _____

Zenpep: 5,000 USP __ 10,000 USP ____ 15,000 USP _____ 20,000 USP _____

Diagnosis and Clinical Information

- checkbox Cystic fibrosis (277.0) checkbox CF with gastrointestinal manifestations (277.03)
checkbox Other conditions, please specify: _____ checkbox Exocrine pancreatic insufficiency (577.8)

Sig/Directions: _____ Dispense 90 Days Estimated Duration of Therapy: _____

I certify that, to the best of my knowledge, the patient for whom this medication is requested meets the foregoing eligibility requirements and has a medical need for the medication:

Physician Signature: _____ Date: _____

(Please remember to attach a copy of your current DEA license the first time that a ZENPEP prescription is written. Thank you!)



1. **Overview.** The Eurand Pharmaceuticals, Inc. Uninsured Patient Assistance Program is designed to provide Eurand Pharmaceuticals, Inc. medications to people for whom a medical need is established, but who cannot afford the cost of therapy and have no other reimbursement options that would enable them to purchase the medications.
2. **Definitions.** For the purpose of this Policy Statement and the Eurand Pharmaceuticals, Inc. Uninsured Patient Assistance Program, the following definitions shall apply:

"Patient"	One on whose behalf an application has been submitted for Benefits under Eurand Pharmaceuticals, Inc. Uninsured Patient Assistance Program.
"Applicant"	A person who submits an application for Benefits under the Program.
"Beneficiary"	An Applicant whose application has been granted in full or part by the Eurand Pharmaceuticals, Inc. Uninsured Patient Assistance Program
"Benefits"	The medication(s) that is/are the subject of the Eurand Pharmaceuticals, Inc. Uninsured Patient Assistance Program.
"You"	The Applicant and/or a Beneficiary, as appropriate from the context of this use.
3. **Signatures Required.** In order to be considered for Benefits under the Eurand Pharmaceuticals, Inc. Uninsured Patient Assistance Program, both You and the treating physician must complete and sign the appropriate sections of an application. If the Patient is under 18, the Patient and his or her parents shall jointly submit and execute the application. Regardless of the age of the Patient, if any person described in the following clauses exists, all such persons must join in submitting and executing the application:
 - a) any person that has legal custody or guardianship over the Patient; or
 - b) any person that has the legal right/power to act on behalf of the Patient; or
 - c) any person that claimed (or can claim the Patient as a dependant on his/her most recent (or next) federal income tax return.

At the Eurand Pharmaceuticals, Inc. Uninsured Patient Assistance Program's request, a person described in subparagraphs (a) – (c) of this paragraph may be required to provide proof of his or her relationship to the Patient. We reserve the right to request information that supports the financial status of family members other than the Applicant.
4. **Access to Information.** Your application for Benefits must allow access to the financial, medical and other information about You required pursuant to the application. In order for the Eurand Pharmaceuticals, Inc. Uninsured Patient Assistance Program to receive certain medical information about You in your application, the Health Insurance Portability and Accountability Act of 1986 and the related Privacy Rule, 45 C.F.R. Parts 160 and 164, (collectively "HIPAA"), requires the Eurand Pharmaceuticals, Inc. Uninsured Patient Assistance Program to obtain Your written authorization. If You do not sign the authorization the Eurand Pharmaceuticals, Inc. Uninsured Patient Assistance Program cannot process Your application and You cannot participate in the Eurand Pharmaceuticals, Inc. Uninsured Patient Assistance Program.
5. **Eligibility.** For purposes of this Policy, the determination of whether a person can afford Eurand Pharmaceuticals, Inc. medications is considered with respect to the individual and, if applicable, family/household members and/or any other person having legal responsibility for the Patient (if the Patient is a minor or a dependant adult). The Eurand Pharmaceuticals, Inc. Uninsured Patient Assistance Program is intended for Patients who are financially disadvantaged and have no other reimbursement options that would enable the Patient to purchase products available by the Eurand Pharmaceuticals, Inc. Uninsured Patient Assistance Program. Only those Patients whose household income equals or is below 200 percent of the federal poverty level adjusted by family size are eligible for participation in the Eurand Pharmaceuticals, Inc. Uninsured Patient Assistance Program at no cost.
6. **U.S. Residents Only.** Only U.S. residents are eligible for Benefits under the Eurand Pharmaceuticals, Inc. Uninsured Patient Assistance Program.
7. **Limit on Supply.** A limited supply of medication may be awarded to a Beneficiary for each application submitted. Treating physicians must reapply if additional supplies are required.



8. No Right to Assistance. Neither a Patient nor an Applicant for Benefits under the Eurand Pharmaceuticals, Inc. Uninsured Patient Assistance Program has a legal right to receive assistance from the Eurand Pharmaceuticals, Inc. Uninsured Patient Assistance Program. Any award of Benefits from the Eurand Pharmaceuticals, Inc. will involve the assessment of many criteria among potentially qualified Patients and Applicants. Therefore, we reserve the right to grant or deny an application, in whole or in part, on the basis of such criteria as we deem appropriate. In particular, the fact that an Applicant or Patient may be granted an award of Benefits at one time does not mean that the Applicant or Patient is entitled to, or will be granted an award of Benefits at any time.
9. Distribution. The Eurand Pharmaceuticals, Inc. Uninsured Patient Assistance Program uses contracted partners for all of its distribution activities, including distribution of the Eurand Pharmaceuticals, Inc. Uninsured Patient Assistance Program medications. The Eurand Pharmaceuticals, Inc. Uninsured Patient Assistance Program is not responsible for the activities of its contracted distributors and any delays in shipment or other problems that might occur with the delivery of medication are solely the responsibility of the contracted distributor. Eurand Pharmaceuticals, Inc.'s Patient Assistance Program medications will be sent to the Patient's physician. The Patient will need to pick up medications from the physician's office.
10. Drug Shortage. The Eurand Pharmaceuticals, Inc. Uninsured Patient Assistance Program will attempt to ensure that sufficient quantities of medications are available to provide You with the amount of medication that You may be awarded under Eurand Pharmaceuticals, Inc. Uninsured Patient Assistance Program. In the event that a shortage of medication exists at any time during a period of time for which You have been awarded medication under the Eurand Pharmaceuticals, Inc. Uninsured Patient Assistance Program, the Eurand Pharmaceuticals, Inc. Uninsured Patient Assistance Program will give You written or verbal notice of that shortage.
11. Waiting Lists. The Eurand Pharmaceuticals, Inc. Uninsured Patient Assistance Program may receive numerous applications resulting in request for more medication than is available to the program. Therefore, the Eurand Pharmaceuticals, Inc. Uninsured Patient Assistance Program may not be able to approve all applications for Benefits. Moreover, a waiting list of Applicants may accrue, which may delay processing applications until sufficient supplies become available to the program.
12. Right to Modify Benefit. We, during the time period of any award to Beneficiary, reserve the right to review the award and/or the Patient's medical and financial situation. Based on that review, we reserve the right to increase, decrease or terminate Benefits previously awarded to You.
13. Additional Restrictions. In the course of reviewing an application and/or administering an award of Benefits under the Eurand Pharmaceuticals, Inc. Uninsured Patient Assistance Program, we reserve the right to impose such other conditions and/or require that You provide such other information and/or that You take such actions as we deem appropriate.
14. No Warranties. The Eurand Pharmaceuticals, Inc. Uninsured Patient Assistance Program does not make any warranties, either expressed or implied, concerning any aspect of the Eurand Pharmaceuticals, Inc. Uninsured Patient Assistance Program.
15. Termination of Program. The Eurand Pharmaceuticals, Inc. Uninsured Patient Assistance Program may be terminated at any time.

Patient Eligibility for Eurand Pharmaceuticals, Inc. Uninsured Patient Assistance Program

Eligibility Patients whose annual **household** income (all household members income must be included) is equal to or less than 200 percent of the federal poverty level for 2008 adjusted by family size are eligible for the Eurand Pharmaceuticals, Inc. Uninsured Patient Assistance Program for Eurand Pharmaceuticals, Inc. medications at no cost. The 2008 HHS Poverty Guidelines that must be met to qualify for medications at no cost.