NeedyMeds
www.needymeds.org

Find help with the cost of medicine

Thank you for downloading this patient assistance document from NeedyMeds. We hope this program will help you get the medicine you need.

REMEMBER - Send your completed application to address on the form, NOT to NeedyMeds.

Did you know that NeedyMeds has thousands of other free resources?

Here's a look at more ways we can help you save money on medicine and healthcare costs. Each one can be found under the **"Patient Savings"** tab on our website:

- **Diagnosis-Based Assistance** — NeedyMeds lists thousands of assistance programs for almost any health condition. If you are going through chemo treatment for cancer, there are programs that can help with wig costs and scalp-cooling products. We also list resources for free diabetes testing supplies, caregiver lodging support, and much more.

- **Free, Low Cost, and Sliding Scale Clinics** — This popular collection contains information on 18,000+ free, low cost, and sliding scale medical and dental clinics across the U.S. It's a great resource if you need affordable medical treatment and don't know where to go.

- **Coupons, Rebates & More** — You can use the NeedyMeds website to find nearly 2,000 cost-saving opportunities for both prescription and over-the-counter drugs and medical supplies.

- **Medical Transportation** — Need help getting to the doctor's office or medical facility? You may be eligible for financial assistance if you meet certain requirements.

Finally, I want to tell you about the NeedyMeds Drug Discount Card. Thousands of people use this free, anonymous, and easy-to-use tool to get the best price on their medications. To date, our drug discount card has saved patients over $244,000,000. Check out the next page to learn more.

Feel free to call our toll-free helpline if you have any questions. You can reach us at 1-800-503-6897 Monday-Friday, 9am-5pm Eastern Time.

Thanks for using NeedyMeds! Please let us know if we can do anything else to help you afford the costs of your healthcare.

Richard J. Sagall, MD
President, NeedyMeds

NeedyMeds.org
P.O. Box 219
Gloucester, MA 01931

Helpline: 1-800-503-6897
Email: info@needymeds.org

www.needymeds.org

Clip the card and save

NeedyMeds
NeedyMeds.org

DRUG DISCOUNT CARD

BIN: 020750
RX PCN: NMeds
RX GRP: PDFPDF
ID: NMNA019309901930

Customer Care
1-888-602-2978

This is a drug discount program, not an insurance plan.

NeedyMeds Drug Discount Card
www.needymeds.org

Patient: You may use this card at any of over 65,000 participating pharmacies to save on all prescription medicines. You cannot use this card with Medicare including part D, Medicaid, or any other state or federal programs unless you choose not to use your government-sponsored program. In addition, you cannot use this card with any health insurance program, but you can use it in place of your insurance if the card offers a better price. For questions call 1-888-602-2978 or visit www.drugdiscountcardinfo.com.

Pharmacist: Administered by Medical Security Company, LLC, Tucson, AZ.

Pharmacy Help Desk: 1-800-404-1031.

Powered by ScriptSave® WellRx

- Save up to 80% on medications*
- Use at over 65,000 pharmacies nationwide including all major chains
- Share the card with friends and family
- Use the card as often as needed
- Free, no fees or registration
- Never expires

What will receive a discount?

All prescription medications are eligible for savings, including over-the-counter medicines and medical supplies written as a prescription, as well as human-equivalent pet medications with a prescription by a veterinarian.

You can also save up to 40% off durable medical equipment, including canes, crutches, splints, incontinence supplies and more. You can also save on diabetic supplies such as glucose meters, test strips, lancets and diabetic shoes. Visit www.needymeds.org/dme to learn more.

What if I have insurance?

Anyone can use the card, but it can't be combined with state or federal insurance. You can use the card instead of insurance if:

- A drug isn't covered by your insurance
- Your insurance has no drug coverage
- You have a high drug deductible
- You have met a low medicine cap
- The card offers a better price than your copay
- You are in the Medicare Part D donut hole

To obtain a plastic drug discount card, send a self-addressed, stamped envelope to:

NeedyMeds Drug Discount Card
PO Box 219
Gloucester, MA 01931

The card is not valid in combination with insurance plans, including Medicare, Medicaid or any state or federal prescription insurance. The card can be used only if you decide not to use your government-sponsored drug plan for your purchases.

* Average savings of 60%, with potential savings of up to 80% or more (based on 2018 national program savings data). All prescription medications are eligible for savings.

This is a drug discount program, not an insurance plan. Discounts are available exclusively through participating pharmacies. The range of the discounts will vary depending on the type of prescription and the pharmacy chosen. This program does not make payments directly to pharmacies. Users are required to pay for all prescription purchases. Cannot be used in conjunction with insurance. You may call 1-888-602-2978 with questions or concerns or to obtain further information.

Arbor Pharmaceuticals Patient Assistance Program ("PAP")
Administered by: Truax Patient Services
1112 Railroad St SE STE#4, Bemidji, MN 56601
Phone: (877) 438-9759 Fax: (877) 438-9759

Dear Applicant,

Thank you for your interest in the Arbor Pharmaceuticals, LLC Patient Assistance Program ("Program"). Enclosed you will find the requested application. To participate in our Program, it is important that you complete all requested information and sign where indicated. Incomplete applications will not be processed until missing information is received.

PATIENT REQUIREMENTS:

- Must be a U.S. citizen or resident, with a valid Social Security Number.
- Patient must have no insurance coverage either private and/or public
    - Medicare Part D Applicants: If Part D does not allow or pay for any part of your medication, you will be viewed as having no insurance. Being in the donut hole does **not** qualify.
- Provide a list of other medications you are currently on.
- Must be under the care of a licensed healthcare provider who is authorized to prescribe medicine in the U.S.
- Complete and sign the Patient Information Section
- Proof of ANNUAL household income documentation is required with each application.
    - Acceptable forms of documentation include:
        - Copy of most recently filed Income Tax Return (IRS Form 1040) or W-2 -or-
        - Copy of transcript received through submission of IRS 4506-T -or-
        - Copy of most recent Social Security/Disability monthly check, award letter, benefit statement of 1099 -or-
        - Copy of Unemployment Determination letter
        - Certified letter stating you have no income in your total household

HEALTHCARE PROVIDER REQUIREMENTS:

- Complete and sign the Healthcare Provider Information section.
- ***Mail, fax or scan the completed application along with a 90-day supply prescription with refills for chronic medication or as prescribed prescription for acute care medication to Truax Patient Services.***
- Provide NPI and DEA Number.

INCOME ELIGIBILITY CRITERIA REQUIREMENTS:

Household Income Requirement: Patient must not have a household income that exceeds 300% of the current US Federal Poverty Guideline (FPL) for BiDil®, and 200% of current US FPL for all other products:

Persons in Household	Annual Income – 200% FPL	Annual Income – 300% FPL (BiDil)
1	$25,520	$38,280
2	$34,480	$51,720
3	$43,440	$65,160
4	$52,400	$78,600
5	$61,360	$92,040

For each additional person(s) add $8,960 for 200% or add $13,440 for 300%

Alaska and Hawaii residence: Please ask Truax Patient Services or find on-line your states US FPL amounts.

SUBMIT COMPLETED APPLICATIONS BY SELECTING ONE OF THE FOLLOWING OPTIONS:

- MAIL: Truax Patient Services / 1112 Railroad St SE STE#4 / Bemidji, MN 56601
- FAX: (877) 438-9759
- Email: bwtruax@truaxpatientservices.com

revised 01/22/20

Reset Form

Medication will be mailed to the patient through Truax Patient Services Pharmacy, unless viewed as a health risk to be mailed to patient's address. You will be notified upon completion of our review and evaluation. Please note, Program rules are subject to change without notice. If you have questions or need further assistance, please call (218-444-8217), between 9:00AM and 5:00PM Central Standard Time, Monday through Friday.

Sincerely,
Arbor Pharmaceuticals, LLC
Patient Assistance Program

Arbor Pharmaceuticals Patient Assistance Program

Truax patient Services / Individual Patient Assistance Program Application

1112 Railroad St SE STE#4 / Bemidji, MN 56601 / Phone: (877) 438-9759 / Fax: (877) 438-9759

PATIENT INFORMATION TO BE COMPLETED BY PATIENT OR LEGAL GUARDIAN					
FIRST NAME:	**MI:**	**LAST NAME:**			**DOB: / /**
Mailing Address:		City:		State:	Zip:
Social Security #:		Phone #: ( )			
Contact person if different from above:			Phone #: ( )		
Drug Allergies:					
Medications currently on:					

PATIENT ELIGIBLITY INFORMATION – ATTACH PROOF OF ANNUAL HOUSEHOLD INCOME (REQUIRED)
TOTAL ANNUAL HOUSEHOLD INCOME: $_____ (include all annual income, wages, social security, pension, disability, interest earned on savings, etc.)
Household Size (number of persons living in the home) :
Are you currently enrolled in a Medicare Part D Prescription Drug Plan? YES☐ NO☐
Do you have any public or private prescription drug coverage or are you in any benefit program that helps pay for your prescription drugs? **YES☐ NO☐**

I certify that all of the above information is complete and accurate. I attest that I have insufficient financial resources to pay for the prescribed medication. I acknowledge and agree not to submit an insurance claim or other claim for payment to any third-party payor (private or government) for the medication. My signature certifies that the medication received from Truax Patient Services will not be resold nor offered for sale, trade or barter and will not be returned for credit. I understand that support services will terminate if the PAP becomes aware of any fraud or if this medicine is no longer prescribed for me. I understand that completing this PAP application does not ensure that I will qualify for patient assistance. I understand and acknowledge that this assistance is temporary and that this Program may be changed or discontinued at any time without notice.

Patient's Signature:_____ **Date:** _____

HEALTHCARE PROVIDER INFORMATION: TO BE COMPLETED BY TH PRESCRIBING PRACTITIONER		
First Name:	Last Name:	MD DO NP PA
Facility Name:	NPI #:	DEA#
Street Address:		
City:	State:	ZIP:
Phone Number:	Fax Number:	

I represent that all information I have provided about this patient is complete, accurate and consistent with applicable privacy laws and regulations, and I understand that Arbor Pharmaceuticals PAP and /or their agents are relying on this information. To the best of my knowledge, this patient has no prescription insurance coverage, including Medicaid, Medicare or other public or private programs. I understand that PAP reserves the right to modify or terminate this Program at any time. I understand that PAP reserves the right to recall or discontinue medication at any time without notice.

Healthcare Provider Signature:_____ Date:_____

Truax Patient Services
Individual Patient Assistance Program Application Disclosure Section
1112 Railroad St SE STE#4 / Bemidji MN 56601 / Phone (877) 438-9759 / Fax (877) 438-9759

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION:

This document authorizes the disclosure and/or use of individually identifiable health information, set forth below, consistent with federal law concerning the privacy of such information.

USE AND DISCLOSURE OF HEALTH INFORMATION:

I hereby authorize the use or disclosure of my health information as follows:

Persons/organizations authorized to use or disclose the information: My insurer, pharmacist, physician or other health care provider.

Purpose of requested use or disclosure: To (1) confirm my eligibility to receive medications under the Program, (2) facilitate my participation in the Program, and (3) administer the Program.

This Authorization applies to the following information: Information about my prescribed medications and medical condition, including prescriptions.

EXPIRATION:

This Authorization expires one (1) year after I cease to participate in the Program.

NOTICE OF RIGHTS AND OTHER INFORMATION:

I may refuse to sign this Authorization, but such refusal would cause me to be ineligible to participate in the Program.

I may revoke this Authorization at any time by calling (651) 587-0964 and mailing a written revocation, signed by me or on my behalf, to Truax Patient Services 1112 Railroad St SE STE#4, Bemidji, MN 56601. My revocation will be effective upon receipt, but will not be effective to the extent that the requestor or others have acted in reliance upon this Authorization. Revocation of the Authorization would cause me to be ineligible for further participation in the Program.

I understand that once health information about me has been disclosed in reliance upon this Authorization, the information may no longer be protected by federal privacy laws and may be further disclosed.

I have a right to receive a copy of this Authorization.

Patient Signature:_____ Date_____/_____/ ____