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

**REMEMBER — Send your completed application to the 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 **"Healthcare 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, dental, mental health and substance abuse 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 2,600+ 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.

NeedyMeds also offers information on diagnosis-based camps and retreats, recreational programs, scholarships, government programs, $4 generic drug programs, and more.

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. Use the card to get discounts on lab tests and also to save 40% on durable medical equipment. To date, our drug discount card has saved patients over $300,000,000. Check out the following page to learn more.

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

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

Rich Sagall, MD
President, NeedyMeds

# 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.

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.

You can also save an extra 5% on affordable lab tests and online results. No doctor's order or insurance needed. Visit www.needymeds.org/L2L for more information.

## 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
50 Whittemore St.
Gloucester, MA 01930

*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.

core Patient

Reset Form



# ENROLLMENT FORM

PLEASE FAX COMPLETED FORM TO **866-676-4073**
FOR QUESTIONS, CALL **888-587-3263**

**Requested Services:** ☐ Benefits Verification ☐ Prior Authorization Support ☐ Patient Assistance Program (PAP) ☐ Commercial Copay Program ☐ Claims Support ☐ Appeals Support ☐ Independent Patient Assistance Foundations Information

## 1 PATIENT INFORMATION (PATIENT TO COMPLETE SECTIONS 1-3)

| | | |
|---|---|---|
| First Name (First MI Last): | | Social Security #: |
| DOB (mm/dd/yyyy): | Phone: | |
| Address: | | |
| City: | State: | ZIP: |
| Contact Name (if other than patient): | Contact Phone: | |
| Permanent U.S. Resident?: ☐ Yes ☐ No | Preferred Language: ☐ English ☐ Spanish ☐ Other | Gender: ☐ Male ☐ Female ☐ Unspecified |

CANNOT process form without this section completed

## 2 INSURANCE AND FINANCIAL INFORMATION

***PLEASE INCLUDE COPY OF INSURANCE CARDS, FRONT AND BACK AND ENLARGED***

Medicare Coverage: ☐ Part A ☐ Part B ☐ Part D ☐ Medicare Advantage | Medicare Policy #: | Effective Date:

If PART D or Medicare Advantage, list Prescription Drug Plan information below:

| | Insurance Name | Phone | ID/Policy # | Group # |
|---|---|---|---|---|
| Primary | | | | |
| Secondary | | | | |
| State Program | | | | |
| Veteran or Other Plan | | | | |

Medicaid ☐ Not applied ☐ Denied ☐ Pending | Veteran ☐ Yes ☐ No | Applied for VA? ☐ Yes ☐ No

Any other government sponsored plan? ☐ Yes ☐ No

*** COMPLETE FINANCIAL INFORMATION ONLY IF APPLYING FOR APPLYING FOR PAP ( E.G. TEVA CARES FOUNDATION)***

Household Adjusted Gross Income: $ _____

Attach copies of proof of income for you and all dependent persons in the household
*Example: Federal income tax (form 1040, 1040EZ, 1099, 1099-DIV, or 1099-I or yearly benefits statement (SSA, 1099, or award)*

Number in household (including you, your spouse, and dependents):

## 3 PATIENT OR PERSONAL REPRESENTATIVE SIGNATURE(S)

### PATIENT AUTHORIZATION

I authorize my healthcare providers, pharmacies, and health plan(s) to disclose my personal health information on this form as well as information related to my medical condition, treatment, care management, prescriptions, and health insurance to Teva Pharmaceuticals USA, Inc. and its affiliates, contractors and agents, including their third party patient support program service provider (collectively "Teva") for the purposes described below.

I understand that the purpose of this Authorization is to provide me with access to services related to my prescribed medication and/or medical condition ("Program"), including (i) enrollment in the Program; (ii) conducting benefits investigation and coordinating my insurance coverage, which may include allowing a Teva field based representative to access my information and engage with my healthcare provider directly, if necessary; (iii) if needed, determining my eligibility for and coordinating financial assistance; (iv) coordinating prescription fulfillment and product replacement; (v) providing nursing support; (vi) facilitating quality and adverse event reporting activities; (vii) conducting data analytics, market research, and Program related business activities; (viii) contacting me by direct mail or by electronic or telephonic means to the contact information on this form or to any future contact information provided by me or on my behalf in connection with carrying out the Program services, including adherence related communications, reminders, and support, for which the third party service provider may receive financial remuneration from the manufacturer of your medication.

I understand that I may cancel this Authorization at any time, by writing to Teva, Attn: Authorizations, P.O. Box 7613, Overland Park, KS 66207, but my cancellation will not apply to any information already disclosed pursuant to this Authorization. This Authorization will remain in effect until the Program ends. I understand that once my information is disclosed, it may be subject to redisclosure by the recipients a nd no longer protected by federal privacy law. I understand that my treatment, payment for treatment, insurance enrollment, or eligibility for insurance benefits will not be directly affected if I do not sign this Authorization. However, if I do not sign this Authorization, I may not be able to receive Program services. I am also entitled to a copy of this signed Authorization.

Patient Signature: ✕ | Date: ✕

If signed by someone other than the patient, describe legal authority to do so:

CANNOT process form without signature and date

### PATIENT DECLARATION

I certify that the information I have provided is truthful and accurate to the best of my knowledge. I understand that any assistance provided to me through the Teva Cares Foundation ("The Foundation") Patient Assistance Program (the "Program") is contingent upon my ability to meet the eligibility criteria for the Program as established by The Foundation and that my application for assistance does not guarantee acceptance into the Program. Any assistance for which I may be eligible will only be awarded after my documentation has been received and approved by the Program. In the event that I am eligible for the Program, I acknowledge that this assistance is temporary and that I may be asked to reapply at designated intervals as determined by the Program. Assistance is not guaranteed for any specific time frame and may be terminated at any time for any reason without any notice to me. I agree that I will notify the Program within thirty (30) days if my insurance or financial situation changes as this may impact my eligibility to participate in the Program. The Program has the right to review its records periodically throughout a patient's enrollment period to verify that the enrolled patient continues to satisfy the eligibility criteria. If this review determines that the patient no longer satisfies the eligibility criteria, the PAP will withdraw the patient from the Program. I certify that I have not received and will not seek to receive reimbursement for the Teva drug requested and/or supplied through the Program. I agree that the Program and its affiliates, agents and representatives shall not be liable for any damages, of any kind, without limitation, in connection with my receiving assistance, benefits, or services provided by the Program. I have read, understand, and agree to all of the above.

Patient Name:

Signature: ✕ | Date: ✕

*If signed by someone other than the patient, describe legal authority to do so:

Personal Representative Name (if applicable): | Signature:

Sign and date Patient Declaration only if applying for PAP (e.g. Teva Cares Foundation)





*We will contact you if additional documentation is required

core

**ENROLLMENT FORM**
PLEASE FAX COMPLETED FORM TO **866-676-4073**
FOR QUESTIONS, CALL **888-587-3263**

# Healthcare Professional

## 1 PHYSICIAN INFORMATION (PHYSICIAN TO COMPLETE SECTIONS 1-3)

| | | |
|---|---|---|
| Physician Name: | DEA #: | NPI #: |
| Medical License #: | MD Tax ID #: | |
| Facility Name: | Group Tax ID #: | |
| Address: | | |
| City: | State: | ZIP |
| Medicaid Provider # and Pin: | PTAN #: | |
| Clinical Contact: | Contact Title: | |
| Contact Phone: | Contact Fax: | |
| Billing Contact: | Contact Title: | |
| Contact Phone: | Contact Fax: | |

**CANNOT process form without this section completed**

## 2 PRESCRIBING INFORMATION

Patient Name (First MI Last): | Date of Birth:

Site of Care: ☐ Physician Office ☐ Facility/Hospital ☐ Patient Home (for SYNRIBO® and GRANIX®)

Is patient being treated outpatient?: ☐ Yes ☐ No

Patient Primary Diagnosis for prescription — ICD-10 Code: Description:

Patient Secondary Diagnosis for prescription — IDC-10 Code: Description:

**Choose Drug Name:**

☐ BENDEKA® (bendamustine hydrochloride) injection ☐ GRANIX® (tbo-filgrastim) Injection ☐ HERZUMA® (trastuzumab-pkrb) for Injection

☐ SYNRIBO® (omacetaxine mepesuccinate) Injection, for subcutaneous use ☐ TREANDA® (bendamustine hydrochloride) for Injection

☐ TRISENOX® (arsenic trioxide) injection ☐ TRUXIMA® (rituximab-abbs) Injection

| Therapy GIVEN | | | Therapy PLANNED for month | | |
|---|---|---|---|---|---|
| Date(s) | Dose | Frequency | Date(s) | Dose | Frequency |
| | | | | | |
| | | | | | |

## 3 PHYSICIAN DISTRIBUTION AND SIGNATURE

If shipping address is the same as the mailing address above, please confirm by checking the box. ☐ If not, please indicate shipping address below

Shipping Address:

City: State: ZIP:

On behalf of my patient, I request assistance for the oncology drug manufactured by Teva Pharmaceuticals ("Teva") specified in this application. I attest that the information contained in this form is complete and accurate to the best of my knowledge and that I have prescribed the drug specified in this application based on my professional judgment of medical necessity. I understand that the patient must meet financial parameters to be eligible under the program. I certify that I have not received, and will not seek to receive, reimbursement for any drug requested, replaced and/or supplied under the Comprehensive Oncology Reimbursement Expertise (CORE) Program. I certify that no free product provided under this Program will be distributed for sale to any individual or organization or returned for credit. I understand that if a retroactive insurer policy change allows for reimbursement of product already supplied at no charge, Teva will bill me for the covered product, and I agree to be responsible for payment of the bill. If I submit a claim to patient's insurance company for services rendered in conjunction with the administration of a product provided under this program, I agree to fully disclose to the insurance company that the product was provided free of charge under this Program. I agree to abide by this certification throughout any participation in the Program and to notify a Program representative if aspects of my certification are no longer applicable. I understand that if the patient's income or insurance status changes, the patient may no longer be eligible under this Program. I agree to immediately notify a Program representative if I become aware that the patient's insurance or income status changes, or if a retroactive insurer policy change allows for reimbursement of product already supplied at no charge. I understand that Teva reserves the right to modify or terminate this Program at any time without prior notice and reserves the right to recall the product when necessary. I understand that I am under no obligation to prescribe any Teva drug to participate in this Program and that I have not received, nor will I receive any benefit from Teva or its agents, for prescribing a Teva drug. I understand that Teva and its agents are not responsible for filing any insurance claim. PAP: I understand that in a number of circumstances, as described in CORE Program supporting material, I will be required to appeal the denial from patient's insurance company before receiving any product under this program. I agree to become familiar with these requirements and certify that in circumstances where an appeal is required: (i) I will submit a claim to the patient's insurance company; and (ii) if the claim is denied I will submit an appeal to the patient's insurance company, prior to requesting free product under this Program. If product is provided by Teva under this Program, I will return to patient any deductibles or co-insurance made by patient for the product.

**CANNOT process form without signature and date**

Physician Signature: ✕ | Date: ✕