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.

Reset Form

# DARAPRIM®
(pyrimethamine) 25mg tablets

# ENROLLMENT FORM
PHONE: 1-844-267-3323 FAX: 1-877-241-1365

*Indicates required field. Please complete all required fields to avoid processing delays.

This form is intended for prescriber use only. Fax both pages of the completed form to 1-877-241-1365.

☐ New Patient ☐ Current Patient

## PATIENT INFORMATION

*Patient Name (Last, First):

*Date of Birth: Gender: M☐ F☐

*Address:

*City: *State: *Zip:

*Cell #: Alt. Phone #:

Email:

Preferred Contact Method: ☐Phone ☐Cell ☐Email

Best Time to Call: ☐Morning ☐Afternoon ☐Evening

Parent/Guardian (if applicable): ☐Principal Contact

*Deliver to (choose one): ☐Patient's Home

☐Other: _____

## PATIENT INSURANCE INFORMATION/PHARMACY BENEFIT PLAN

**Please complete the fields below or include a copy of the front AND back of the patient's prescription benefit and insurance card(s).**

*Insurance: ☐Commercial ☐Government ☐Uninsured

*Primary Insurance: Pharmacy Help Desk #:

Policyholder Name: *Relationship to Patient:

*Member ID #: *Group ID #:

*Rx BIN #: *PCN #:

Secondary Insurance: Pharmacy Help Desk #:

Member ID #: Group ID #:

Rx BIN #: PCN #:

Special Instructions:

## PRESCRIBER INFORMATION

*Prescriber Name (Last, First):

Prescriber Practice Title:

MD Specialty:

*NPI #: Physician Medicaid UPIN #:

State License #: DEA #:

*Address:

*City: *State: *Zip:

*Phone #:

*Fax#:

*Staff Contact Name:

*Staff Contact #:

Staff Contact Email:

## PATIENT DIAGNOSIS

*ICD-10 Code/Description:

*Please list any known allergies to medication or other substances:

## PRESCRIPTION INFORMATION

*Patient Name (Last, First):

Drug: **DARAPRIM® (pyrimethamine) 25mg tablets**

*Quantity: *Refills:

*Directions:

*Start Date: Anticipated Duration:

Additional Prescription(s):

## PROVIDER ATTESTATION

**Prescriber signature must be the same as the prescriber name above**

By signing below, I verify that the information being disclosed in this enrollment form is complete and accurate to the best of my knowledge. I understand that Optime Care, Inc. (OC) reserves the right at any time and for any reason, without notice, to modify this enrollment form or to modify or discontinue any services or assistance provided through this Program. I have received the necessary legal authorization from the patient to disclose the patient's protected health information to OC, Vyera Pharmaceuticals, LLC, and their respective affiliates, representatives, agents, and contractors, including any patient assistance program administrator(s), in connection with the Program, including but not limited to for purposes of verifying the accuracy of any information provided, verifying patient eligibility, and/or providing for payment and reimbursement. I authorize OC to transmit prescribing information, by fax or other mode of delivery, to a pharmacy for fulfillment. I have prescribed Daraprim based on my professional judgment of medical necessity. Any medications supplied by Vyera Pharmaceuticals, LLC as a result of this form are for use by the named patient only and shall not be sold, traded, bartered, transferred, returned for credit, or submitted to any third-party payer (private or government) for reimbursement.

*Prescriber's Signature: *Date:

(No Stamps) (Dispense As Written)

*Prescriber's Signature: *Date:

(No Stamps) (Substitutions Permitted)





**Please see accompanying Full Prescribing Information**

DAR2019021

**DARAPRIM®**
(pyrimethamine) 25mg tablets

# ENROLLMENT FORM

PHONE: 1-844-267-3323 FAX: 1-877-241-1365

Fax both pages of the completed form to 1-877-241-1365.

## PATIENT REPRESENTATIVE (IF APPLICABLE)

By signing below, I authorize my Designee, listed below, to receive administrative information related to my treatment, such as appointment reminders, and to make decisions on my behalf—for which I will remain liable—regarding delivery of DARAPRIM® (pyrimethamine). Optime Care, Inc., and its affiliates, representatives, agents and contractors is not liable for any decision(s) made by the Designee or actions taken in reliance on such Designee decisions.

Designee Name: Relationship: Phone #:

Patient's Signature: Date:

## PATIENT AUTHORIZATION

I, or my authorized representative, hereby authorize the pharmacy receiving my referral or dispensing my medication, and its affiliates, representatives, agents, and contractors (collectively, "Pharmacy"), to use and disclose all of my individually identifiable health information; protected health information including but not limited to records that may contain information created by other persons or entities, including physicians and other health care providers, as well as information regarding the use of drug and alcohol treatment services, confidential HIV/AIDS treatment, mental health services (excluding psychotherapy notes), information about my medical condition, prescription, treatment, care management, and health insurance; and any other personal information, including all demographic information, email addresses, phone numbers, and other information, in the possession or control of Pharmacy (collectively "Information"), to Optime Care, Inc. ("Optime Care"), Vyera Pharmaceuticals, LLC, and their respective affiliates, representatives, agents, and contractors, including any patient assistance program administrator(s), for Daraprim.

The Information may be used and disclosed for purposes of: (1) providing, coordinating, managing, and contacting me about, my prescriptions (including medication refill and adherence reminders), treatment, patient support, and other services related to my Vyera products including providing information to the pharmacy dispensing my medication; (2) establishing my benefits eligibility, including for any financial or reimbursement support services offered by or on behalf of Vyera; (3) communicating with me and my healthcare providers, health plans, and other payers about my medical care; and (4) providing me with information about current or future products or services.

I understand that Pharmacy may receive a fee from Vyera in exchange for (1) providing me with certain materials and information described above, and (2) using or disclosing certain Information pursuant to this Authorization. I also understand that once my Information has been shared with Vyera or Optime Care, it may be re-disclosed by Vyera or Optime Care and no longer protected by the federal Privacy Rule. However, other state and federal laws may establish continuing protections for the disclosed information and prohibit Vyera or Optime Care from disclosing specially protected information such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.

I understand that I may revoke this Authorization at any time, in writing, by sending written notification to Optime Care, Inc., 4060 Wedgeway Court, Earth City, MO, 63045. I understand that revoking this Authorization will prohibit disclosures of my information after the date the cancellation letter is received, but will not affect disclosures made by Pharmacy to Vyera or Optime Care in reliance on this Authorization.

I understand that signing this Authorization is voluntary. I have the right to refuse to sign this Authorization and my refusal to sign will not affect my ability to obtain treatment or my eligibility for health plan benefits, and my Information will not be released. However, I understand that I will not have access to additional patient support, financial, or related services offered by Vyera. This authorization expires December 31, 2099, or at an earlier date if required by state law. I understand that I have the right to receive a copy of this Authorization.

Patient or Authorized Representative Signature: If Authorized Rep, State Basis for Authority:

Patient's Printed Name: Date:



VYERA PHARMACEUTICALS



**Please see accompanying Full Prescribing Information**