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.

Reset Form

Saol THERAPEUTICS

Lioresal® Intrathecal (baclofen injection) Patient Assistance Program

Lioresal® Patient Assistance Program
PO Box 219, Gloucester, MA 01931
Phone: 877-222-7715 Fax: 888-246-6527

Applicant's Name: _____ Date of Birth: _____

Patient Instructions:

1. Complete all fields on page 1 and 2 of the application. Have your prescriber complete page 3 and 4 of the application. Read and sign the HIPAA Authorization on page 5. Incomplete applications will delay the processing of your application.
2. Sign the application.
3. Send the application to the Lioresal® Patient Assistance Program.

NOTE: For medications shipped to Nebraska you must include a copy of a state issued photo ID.

INFORMATION

Name (First and Last): _____

Street Address: _____

City: _____ State: _____ ZIP Code: _____ Daytime Phone: _____

Social Security # or Green Card # (if applicable) _____ Date of Birth: _____

Email: _____
By providing your email you are giving us permission to contact you concerning your patient assistance program application in this way.

Fax: _____
By providing your fax you are giving us permission to contact you concerning your patient assistance program application in this way.

ELIGIBILITY INFORMATION

Residency Status: ☐ U.S. Citizen ☐ Legal Resident ☐ Work Visa (attach a copy your work visa)

Gender: ☐ Female ☐ Male

My annual household income: _____

Required supporting documentation (select one):

- ☐ Applying before April 15 - copy of the first page of last year's tax return
- ☐ Applying after April 15 - copy of the first page of this year's tax return
- ☐ If on Social Security a copy of SSA 1099
- ☐ Copy of two most recent pay stubs for all employed household members
- ☐ Proof of all pensions, interest, alimony, child support and retirement payments for all household members
- ☐ If applicant has no income then a letter is required from applicant's healthcare provider, advocate or other person or agency attesting to zero income of if you don't file taxes, submit Form 4506-T from the IRS.

My household size: _____

Check one:

- ☐ I have no health insurance coverage (private or government) that pays for Lioresol® Intrathecal and have not been insured for at least three months
- ☐ I had health insurance coverage (private or government) that paid for Lioresol® Intrathecal within the last three months but it expired. Date of expiration: _____ Insurer: _____

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MEDICAL QUESTIONS

List all the medications you are currently taking, including over-the-counter medicines (those you can buy without a prescription), supplements, natural remedies, etc. If you are taking no medications, then check this box: ☐ NONE.

_____
_____
_____
_____

List any allergies to medications you have. If you have no allergies, then check this box: ☐ NONE.

_____
_____
_____
_____

List any medical conditions you have, including any relative to this voucher.
If you have no medical conditions, then check this box: ☐ NONE

_____
_____
_____
_____

THE AGREEMENT

You must sign the form before we can process your application and deliver your medication. I attest that the information in this application is true, complete and accurate. This authorization or a copy shall be valid for 12 months from the date of signature. I further agree that the medication obtained through this program will not be sold, traded, bartered, transferred or returned for credit. I understand that the Lioresal® Patient Assistance Program reserves the right to request additional income verification or other information from me and may refuse my application based on any misuse, abuse or illegal distribution of any products in this program. I will notify the program immediately should I become aware of any information in this application has changed.

Applicant's Signature: _____ Date: _____

If applicant is under 18 years of age or unable to apply by themselves, please provide caregiver's signature:

Caregiver's Signature: _____ Date: _____

Saol THERAPEUTICS

Lioresal® Intrathecal (baclofen injection) Patient Assistance Program

Lioresal® Patient Assistance Program
PO Box 219, Gloucester, MA 01931
Phone: 877-222-7715 Fax: 888-246-6527

Applicant's Name: _____ Date of Birth: _____

PRESCRIBER INSTRUCTIONS

Complete all fields on the application.

1. Sign the application.
2. Attach a prescription for Lioresal® Intrathecal for one refill kit with up to a maximum of 5 refills.
3. Mail the application to: Lioresal® Patient Assistance Program, PO Box 219, Gloucester, MA 01931. Original prescription must be mailed, faxed or escribed to:
   GoGoMeds, 525 Alexandria Pike, Ste. 100, Southgate, KY 41071. Fax: 844-364-1334. NCPDP #1834793.

Incomplete applications or missing information will delay the processing of the application.

PRESCRIPTION INFORMATION

Lioresal® Intrathecal is available in five different refill kits. Your prescription must be for one of the kits listed below. You may write for one kit with a maximum of five refills. Only one kit is sent at a time. Your office must contact this program to obtain refills. The medicine is shipped to your office or you may designate another medical facility to receive it.

Check one of the options below that applies:

☐ Model 8561: one ampule containing 10 mg/20 mL (500 mcg/mL) (NDC 58281-560-01).

☐ Model 8562: two ampules, each contains 10 mg/5 mL (2000 mcg/mL) (NDC 58281-561-02).

☐ Model 8564: one ampule containing 40 mg/20mL (2000 mcg/ml) (NDC 58281-563-01).

☐ Model 8565: two ampules, each contains 10 mg/20 mL (500 mcg/mL) (NDC 58281-560-02).

☐ Model 8566: two ampules, each contains 40 mg/20mL (2000 mcg/mL) (NDC 58281-563-02).

☐ Model 8563S: one ampule, each contains .05 mg/1mL (50 mcg/mL) (NDC 58281-562-01).

PATIENT INFORMATION

Please select one or more of the following diagnoses that justify the need for this medication:

☐ Severe spasticity

☐ Other _____ICD-10 _____ (Must be FDA-approved use)

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Applicant's Name: _____ Date of Birth: _____

PHYSICIAN INFORMATION

Prescriber's Name: _____ Facility/Practice: _____

Address: _____ City: _____ State: _____ ZIP Code: _____

Telephone: _____ Fax: _____

DEA Number_____ NPI Number _____

Ship To Address for Medication: ☐ Same as above ☐ Use address below

Address:_____

City: _____ State: _____ ZIP Code: _____

State License Number _____ Expiration Date _____

Email: _____
By providing your email you are giving us permission to contact you concerning your patient assistance program application in this way.

Fax: _____
By providing your fax you are giving us permission to contact you concerning your patient assistance program application in this way.

PRESCRIBER ATTESTATION

You must sign the form before we can process your patient's application and send the medication.

I attest that the information in this application is true, complete and accurate. This authorization or a copy shall be valid for 12 months from the date of signature. I understand that the Lioresal® Patient Assistance Program reserves the right to request additional information from me and may refuse my application based on any misuse, abuse or illegal distribution of any products in this program. I further agree that the medication obtained through this program will not be sold, traded, bartered, transferred or returned for credit. I understand that Saol may change or discontinue the Patient Assistance Program at any time with or without notice.

To the best of my knowledge, this patient is financially needy, has no insurance coverage for Lioresal® and has a medical need for this medication. I will notify the program should I become aware of any information in this application has changed.

Prescriber's Signature: _____ Date:_____
(No signature stamps and no delegation of signature authority)

Lioresal® Patient Assistance Program
PO Box 219, Gloucester, MA 01931
Phone: 877-222-7715 Fax: 888-246-6527

Applicant's Name: _____ Date of Birth: _____

Patient Authorization to Use and Disclose Protected Health Information in Connection with Saol Patient Assistance Program

By signing this Authorization, I authorize my health care provider(s) and their staff, my health plan(s), insurer(s), and pharmacy provider(s) to use and disclose my personal health information, including, but not limited to, information relating to medical conditions, treatment, care management and health insurance ("Protected Health Information" or "PHI"), as well as all information provided on this Saol Patient Assistance Program ("PAP") Application form and any related prescription, to NeedyMeds, Inc. as administrator of the Saol PAP and its representatives, agents, and contractors (collectively "NeedyMeds") for the following purposes: (1) to establish my eligibility to participate in the Saol PAP; (2) for purposes relating to the operation and administration of the Saol PAP, including measuring and tracking the quality of the services provided; (3) to communicate with my health care provider(s) and me about the Saol PAP and my medical care; (4) to facilitate the provision of products, supplies or services by a third party, including, but not limited to, specialty pharmacies; (5) to send me information about other programs that might help me pay for my medication and to register me in any applicable product registration program required for my treatment; (6) to communicate with me about my financial, insurance and/or medical information and share my information as required or permitted by law; and (7) to receive communications from NeedyMeds regarding my participation in or experience with the Saol PAP. PHI that may be used or disclosed under this Authorization includes any information related to my health insurance or plan benefits and other information related to treatment, medical conditions, and care management, including possible sensitive material relating to sexually transmitted diseases, mental health conditions, and/or genetic testing.

I authorize Saol and NeedyMeds as administer of the Saol PAP to further use and disclose my PHI in connection with the Saol PAP. I further authorize Saol and NeedyMeds to share my PHI with people and companies that work with NeedyMeds in connection with the PAP, government agencies (including the Centers for Medicare and Medicaid Services), insurance companies, my health care provider(s), and other individuals or institutions that are involved in my healthcare, such as pharmacies and hospitals, and/or other organizations that might help me pay for my medication. I understand that information that may be released in connection with the Saol PAP may also include my name, address, social security number, income, prescription coverage, prescription for medication(s), financial documents, and insurance records.

I understand that Saol and NeedyMeds will keep my PHI and other personal information private, but that once it is released pursuant to this Authorization, it may be re-disclosed by recipients and may no longer be covered by federal and state privacy laws.

I understand that I may refuse to sign this Authorization and that my treatment, payment, enrollment or eligibility for benefits is not conditioned on my signing this Authorization. However, if I do not sign this Authorization, I understand that I would not be able to participate in the Saol PAP. I understand that I am entitled to a copy of this Authorization, and that I may inspect or obtain a copy of the information disclosed pursuant to this Authorization. I also understand that I may cancel this Authorization at any time by calling Lioresal® Patient Assistance Program at 877-222-7715 or by mailing written notice requesting such cancellation to the following address: Lioresal Patient Assistance Program, PO Box 219, Gloucester, MA 01931, but that such cancellation would not apply to any information already used or disclosed pursuant to this Authorization. I understand that should I cancel this Authorization, I may not receive or I may stop receiving the services provided under the Saol PAP.

This Authorization will expire one year from the date signed below. A photocopy of this Authorization will be treated in the same manner as the original.

_____ _____

Applicant's or Applicant Representative's Signature Date

If signed by Applicant Representative, describe relationship to Applicant and authority to make medical decisions for Applicant: