

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



**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](http://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](http://www.drugdiscountcardinfo.com).

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

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



- 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](http://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](http://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.



## ViatriS Patient Assistance Program (PAP) Application

| Phone: 888-417-5780 | Fax: 877-427-7290 | M-F, 8AM to 5PM EST |

**Please complete application in full, sign and date, then fax to:  
877-427-7290**

Or email to: [ViatriSPAP@viatris.com](mailto:ViatriSPAP@viatris.com)

- The PAP Application must be complete to be reviewed for patient program eligibility. Please ensure all areas of the form are completed in full, including all signatures.
- To be considered for the ViatriS Patient Assistance Program, all applicants must satisfy the following requirements and eligibility criteria:
  - Applicants qualify for the program financial requirements.
  - Applicants must be a current United States resident (*includes U.S Territories*).
  - Applicants must be Uninsured.
  - The requested product must be prescribed by a licensed U.S. healthcare professional for a Food and Drug Administration (FDA) approved indication.
- Each applicant will be individually assessed for program eligibility based on the information provided within this application.
- Applicants will only be evaluated for eligibility upon receipt of a completed and signed ViatriS Patient Assistance Program (PAP) Application.

# Viatris Patient Assistance Program Application

| Phone: 888-417-5780 | Fax: 877-427-7290 | M-F, 8AM to 5PM EST |



## Patient Demographic Information

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SSN: \_\_\_\_\_  
First Last Mo Day Year (Required)

Address\* \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Patient Email Address: \_\_\_\_\_

Preferred Contact:  Cell Phone  Home Phone  Email Best Time to Call:  Morning  Afternoon  Evening Gender: \_\_\_\_\_

Insurance:  Uninsured  Commercial  Government  Other

Insurance Name: \_\_\_\_\_ Insurance ID Number: \_\_\_\_\_ \*No PO Boxes Accepted

Number of people in the household: \_\_\_\_\_ Gross Annual Household Income: \_\_\_\_\_ Gross Monthly Household Income: \_\_\_\_\_  
(Including all Income, Wages, Social Security, Pension, Disability, Unemployment Benefits, Financial Assistance, etc.)

Proof of Household Income will need to be submitted with the application.

Approved Verification Documents: 1040; 1040ez; W2; 4506-T; SSI Statement; Disability Statement; Statement from Physician, Nurse, or Patient Advocate; or Certified Notarized Statement from the Applicant.

## Prescriber Information

Prescriber Name: \_\_\_\_\_ Prescriber NPI: \_\_\_\_\_

Facility Name: \_\_\_\_\_ State License #: \_\_\_\_\_

Facility Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Primary Office Contact: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Office Contact Email: \_\_\_\_\_

## Prescriber Shipping Address *(Only complete if shipping address is different than address listed above)*

Prescriber Name: \_\_\_\_\_ Facility Name: \_\_\_\_\_

Shipping Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Shipment Contact Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Contact Email: \_\_\_\_\_



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# Viатris Patient Assistance Program Application

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## Ohio Prescriber Mandatory Subsection *(Select an option below, complete the related fields, then sign & date):*

### **MANDATORY SUBSECTION FOR ALL OHIO HCPs**

Under Ohio law, Mylan Pharmaceuticals Inc., a Viатris Company, may only provide prescription drugs to a prescriber whose practice is licensed as a Terminal Distributor of Dangerous Drugs ("TDDD") or is exempt from such licensure under Ohio Revised Code ("ORC") § 4729.541. A TDDD license allows a business entity to receive, purchase, and possess prescription drugs, including drug samples, for distribution to patients. For more information on TDDD licensing requirements for prescribers, please visit the Ohio Board of Pharmacy website at [www.pharmacy.ohio.gov/PrescriberTDDD](http://www.pharmacy.ohio.gov/PrescriberTDDD), and for a list of exemptions, please refer to section 4729.541 of the ORC. The above information is being provided for your convenience and is not offered, nor should it be construed, as legal advice.

**Please select and complete one of the following and sign below:**

The practice at which I work, \_\_\_\_\_, located at the address I provided above, has an active TDDD license that allows me to receive and store the requested prescription drug products at this location. The TDDD license number is \_\_\_\_\_ which expires on \_\_\_\_\_.

**-OR-**

The practice at which I work, \_\_\_\_\_, located at the address I provided above, is subject to one of the TDDD licensing exemptions in ORC § 4729.541.

By signing below, I warrant that the information provided above is complete and accurate and attest that I can receive and store the requested prescription drug products at the address I provided because I hold an unrestricted, active TDDD license or my practice is exempt from obtaining a TDDD license under ORC § 4729.541.

Prescriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
*(Original signature -and- date required, stamped signatures not accepted)*

## Product & Prescription Information *(Select a Product & Complete Rx Details)*

### Clozapine Tablets

25mg ODT 100s	100mg ODT 100s	25mg T 100s	50mg T 100s	100mg T 100s	200mg T 100s
_____ QTY	_____ QTY	_____ QTY	_____ QTY	_____ QTY	_____ QTY

## Prescription Details- *Please complete all relevant prescription details below*

Patient Name: \_\_\_\_\_ Patient DOB: \_\_\_\_\_

Prescriber Name: \_\_\_\_\_ Prescriber NPI: \_\_\_\_\_

Day Supply: \_\_\_\_\_ Refills: \_\_\_\_\_

Directions: \_\_\_\_\_



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## Prescriber Certification and Prescription Signature

I certify that the information provided in this Patient Assistance Program Application is complete and accurate to the best of my knowledge, that the Viatris product I have prescribed to the applicant within this application is based on my professional judgment of medical necessity for a Food and Drug Administration (FDA) approved indication, and that I will supervise the patient's medical treatment. I will notify Viatris PAP immediately if the Viatris product is no longer medically necessary for this patient's treatment. I certify that I have obtained from my patient all required written authorizations for the release of my patient's personal identification and insurance information to Viatris and their agents and representatives.

I understand that any information provided to Viatris and its agents and representatives is for the sole use of Viatris and their agents, service providers, and representatives to verify my patient's insurance coverage status, to assess the patient's eligibility for participation in the Viatris Patient Assistance Program (collectively, "the Program"), and to otherwise administer the product and related services. I understand that application to the Program does not guarantee that assistance will be obtained.

I understand that Viatris may change or cancel this program at any time. I understand that if my patient's financial and/or insurance status changes, the patient may no longer be eligible for the Program, and I agree to immediately notify a Viatris PAP representative if I become aware of changes in the patient's financial and/or insurance status. I agree that Viatris PAP may contact me for additional information relating to this application either by fax, e-mail and/or telephone. I understand that I am under no obligation to prescribe any Viatris product and that I have not received, nor will I receive any benefit from Viatris or its agents or representatives for prescribing a Viatris product. I agree that I will not sell, submit claims or make any attempt to receive reimbursement from any third party for any product provided by the Program.

Prescriber acknowledges that in connection with the application and enrollment process, United BioSource Corporation (UBC) performs eligibility screening using the Surescripts network. Surescripts requires that Prescriber agree to comply with all Surescripts' terms and conditions, including confidentiality, commercial messaging, privacy and security, applicable laws, and use of data. All Surescripts disclaimers apply. A full list of terms and conditions is available at <https://ubc.com/surescriptsterms/>.

By signing this Patient Assistance Program Application, I authorize the release of medical and/or other patient information to agents and service providers of Viatris to use and disclose as necessary for verification of patient eligibility, and to furnish any information on this form to the insurer of the applicant for the purpose of verifying benefit eligibility. I understand that Program duration per eligibility period is 12 months, and the maximum number of refills per eligible patient is 11 for each unique enrollment.

**Prescriber Certification & Prescription Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(original signature required)

## Pharmacist Authorization and Agreement Signature

Pharmacist Name: \_\_\_\_\_ Professional Designation: \_\_\_\_\_

Facility Name: \_\_\_\_\_ State License #: \_\_\_\_\_

Facility Address\* \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Primary Office Contact: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Office Contact Email: \_\_\_\_\_

\*No PO Boxes

I acknowledge I have completed all certifications with the Clozapine REMS program. By signing this document, I acknowledge my intention and the intention of all dispensing pharmacists in this pharmacy to adhere to the criteria set forth for the Viatris Patient Assistance Program (the "Program"). The pharmacist agrees to receive delivery of Mylan CLOZAPINE Tablets every three months (either in bottle of 100 doses or unit dose packages of 100) and to dispense up to 84 days of medication as prescribed by the physician free-of-charge to the patient in compliance with the Program. (Note: There will be no compensation from Viatris or any of its affiliates for these actions). I understand that Viatris reserves the right to modify or terminate this Program at any time. My signature certifies that the medication received from the Program will not be resold or offered for sale, trade or barter, and will not be returned for credit. I further certify that no reimbursement of the cost of product has been/will be accepted by the pharmacy for any treatments where product has been/will be provided free-of-charge by the Program, including any product that has already been administered to the patient and for which replacement product will be provided to the pharmacy. I understand that Viatris reserves the right to recall or discontinue product at any time without notice.

**Pharmacist Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(original signature required)



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## Patient Authorization and Agreement Signature

By signing this Authorization, I authorize each of my physicians, pharmacists, including any non-commercial pharmacy that receives my prescription ("my Prescribed Product"), and other healthcare providers (together "Healthcare Providers") and each of my health insurers, if any (together, "Insurers") to disclose my Protected Health Information, including but not limited to medical records, information related to my medical condition and treatment, my health insurance coverage, my name, address, telephone number, Social Security number, insurance plan and or group numbers (together, "Protected Health Information") to Viatris, its affiliated companies, vendors, agents, collaboration partners, and representatives (together, "Viatris") including providers of alternate sources of funding for prescription drug costs, and other service providers supporting the Viatris Patient Assistance Program (PAP) (collectively, the "Program") for the purposes described below.

Specifically, I authorize disclosure of my Protected Health Information in order to:

- I. Enroll me in, and contact me about the Program, including online support, financial assistance services, and co-pay assistance services, as applicable,
- II. Communicate with my Healthcare Providers and Insurers about benefits, coverage, and medical care, including compliance with Product treatments,
- III. Facilitate dispensing of my prescription by a non-commercial pharmacy,
- IV. Provide me with educational materials, information and services related to my treatment experience with my prescribed medication and my condition,
- V. Verify, investigate, and coordinate with my Insurers regarding my prescribed medication, and
- VI. Contact me as otherwise required or permitted by law.

Once my Protected Health Information has been disclosed to Viatris, I understand that federal privacy laws no longer protect the information. However, Viatris agrees to protect my Protected Health Information by using and disclosing it only for the purposes described in this Authorization or as permitted by law. I understand that I may refuse to sign this Authorization. My choice about whether to sign will not change the way my Healthcare Providers or Insurers treat me, but I will not have access to the Viatris Patient Assistance Program and the services provided by Viatris under the Program. If I refuse to sign the Authorization, or revoke my Authorization later, I understand that this means I will not be able to participate in or receive assistance from the Program.

I understand that my signed Authorization is valid for 5 years from the date of my signature, and that I may revoke this Authorization at any time in the future, except to the extent that actions have been taken in reliance on the Authorization. I understand that to revoke this Authorization I may mail a request to 5005 Greenbag Road Morgantown, WV 26508, fax to 877-427-7290, or by calling 888-417-5780. I understand that revoking this Authorization will end further uses and disclosure of my Protected Health Information by the parties identified above except to the extent those uses and disclosures have been made in reliance upon this Authorization as permitted by applicable law. I am entitled to receive a copy of this Authorization.

I understand that if I qualify and I am enrolled in the Program sponsored by Viatris, I will receive my Prescribed Product from Viatris only pursuant to a legally valid prescription from my health care provider. I understand that if I qualify and I am enrolled in the Program, Viatris will provide me my Prescribed Product free of charge for the duration of the enrollment period so long as I have a legally valid prescription for my Prescribed Product. I understand that I am not required to continue treatment with my Prescribed Product if I gain insurance coverage, or to receive treatment from any given provider. I understand and agree that I must notify Viatris PAP at 888-417-5780 immediately if my insurance status changes during the Program enrollment period. I understand and agree that neither I nor my Insurers, if applicable, will be charged for the supply of my Prescribed Product that I received from the Program, and that under NO circumstances may I claim reimbursement from my Insurers or any other third party for the Prescribed Product provided to me free of charge from the Program. I understand that Viatris reserves the right at any time without notice to modify or discontinue the Program and its criteria.

I understand that I am providing 'written instructions' to Viatris under the Fair Credit Reporting Act authorizing Experian on behalf of Viatris to obtain information from my credit profile or other information from Experian. I authorize Viatris and its service providers to obtain such information solely for the purpose of determining financial qualifications for the Program. I understand that I must affirmatively agree to the terms in this notice by signing below in order to proceed in the Program financial screening process.

**My signature certifies that I have read and understand the above statements and agree to the outlined terms.**

**Patient Name (Print):** \_\_\_\_\_ **Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## Patient Authorized Representative

I permit Viatris PAP Support Services representatives to speak with the following person about this application form. This includes discussing the status of my application, insurance and financial questions, any missing documentation and other issues related to my enrollment, or any other treatment- related issues. I may cancel this Patient Authorized Representative Authorization at any time by calling: 888-417-5780

Name of Authorized Representative: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Email: \_\_\_\_\_

**By signing below, I, the patient, allow this representative to speak on my behalf on any matter regarding my enrollment with the Program.**

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



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