Cortrophin In Your Corner™

Purified Cortrophin® Gel
repository corticotropin injection USP 80 U/mL

Serva Health LLC ATTN: CIYC PAP
1000 Bishops Gate Blvd Ste 201
Mount Laurel, NJ 08054

ANI Pharmaceuticals Patient Assistance Program Application

- Download the application and fill it out completely before submitting.
- If you have any questions, call 1-888-249-2669 (toll free)
- There are 2 ways to submit the application:
  - Mail the completed application and supporting materials to:
    Serva Health LLC ATTN: CIYC PAP
    1000 Bishops Gate Blvd Ste 201
    Mount Laurel, NJ 08054
  - Fax the form with any other supporting materials to
    1-833-477-8839

1. Patient Information

First Name _____ MI _____ Last Name _____ Gender ☐M ☐F

Mailing Address _____ City _____ State _____ ZIP _____

Home Phone _____ Leave Message? ☐Y ☐N Cell Phone _____ Leave Message? ☐Y ☐N

Email _____ Date of Birth _____ SSN _____

2. Prescriber Information

Physician Name _____ Physician NPI _____

Address _____ City _____ State _____ ZIP _____

Primary Phone _____ Secondary Phone _____

Email _____ Fax _____

3. Insurance Information

Does the patient have health insurance? ☐Y ☐N

☐ If yes, attach a copy of prescription insurance card. If not, complete information below for all insurers (attach additional information if needed):

Insurance Name _____ Member ID _____

Insurance Phone Number _____ RxGroup # _____

Policyholder's Name _____ RxBIN # _____

Policyholder's Date of Birth _____ RxPCN # _____

Does patient participate in any of the following? Check all that apply:

☐ Medicare
☐ Medicare HMO or Medicare + Choice or Medicare Advantage
☐ Medicare Program for Reimbursed Self-Injectable Drugs
☐ Medicaid
☐ Any other federal healthcare program(s), please list: _____
☐ Veterans Administration Programs
☐ Indian Health Service Programs
☐ Public Health Service Programs
☐ Department of Defense Programs
☐ TRICARE/CHAMPUS

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210 Main Street West
Baudette, MN 56623

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4. Financial Information

How many people live in your household? ☐1 ☐2 ☐3 ☐4 ☐5 ☐Other

Total annual household income (including salary/wages, social security income, disability income, any other income):* _____

*The following supporting documentation or other verification is required. Acceptable forms of documentation include: federal income tax return or forms for most recent filing year (1040, 1040EZ, 1099, 1099-DIV); yearly benefits statement (SSA, 1099, or awards letter); W-2 for most recent tax year; pay stubs for 1 month of pay within the last 90 days; unemployment letter or workers compensation; and/or Food and Shelter letter from the Medical Doctor Office (MDO) physically signed by someone from the MDO and on office letterhead.

5. Patient Certification

I certify that, as of the date of my signature, the information provided in this application is complete and accurate to the best of my knowledge and that all of the insurance plans and programs through which I obtain health care coverage are listed above or have been provided separately to the ANI Patient Assistance Program. I understand that the Program is entitled at any time to request verification of any such information which I agree to provide from me, my insurer, and/or other benefit providers; and, among other things, request such information, verify my application status, and/or confirm my receipt of the drug(s) dispensed through the Program. I authorize ANI Pharmaceuticals, Inc., and its partners or agents (and any agents thereof) to request documentation from me, my employer, my health care provider, or my insurance company and to obtain information from these and other companies, including obtaining credit reports and other information from consumer reporting agencies, credit reporting agencies or data brokers to confirm or verify my financial eligibility. I understand that completion of this application and the provision of the requested documentation does not guarantee I will be approved for the Program and eligibility is subject to the Program's sole discretion. I understand the Program reserves the right at any time and without notice to me to modify and/or discontinue any or all of the Program. If eligible to receive assistance, I understand there is no purchase requirement associated with such assistance. Further, any product provided to me at no charge will be provided on a complimentary basis; I will not submit or cause to be submitted any claims for payment or reimbursement to any third-party payer, including a Federal health care program for such product; I will not sell, trade, or distribute or otherwise transfer the Program drugs; and the cost of the product will not count toward any Medicare true out-of-pocket ("TrOOP") costs. If approved, as required by my insurance or other benefit provider, I will notify such provider of my receipt of any drug(s) through the Program. The Program does not cover or provide support for supplies, procedures, or any physician-related services associated with ANI patient therapy. I understand that I must re-apply for the Program annually.

Patient Name (please print): _____ Date: _____

Patient Signature (original signature required): _____ Date: _____

Legal Representative Name (please print): _____

Parent/Guardian/Legal Representative Signature: _____ Date: _____

If signed by a Personal Representative, please describe your authority to act on behalf of the patient: _____

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