AlbireoAssist®
Personalized Support Services
HELPING NAVIGATE THE WAY

Bylvay® (odevixibat)
200 | 400 | 600 | 1200 mcg capsules

# Patient Assistance Program Application

**A patient may be eligible for this program if the following criteria are met:**

- Patient does not have any prescription drug coverage for Bylvay® (odevixibat)
- Patient has been diagnosed with progressive familial intrahepatic cholestasis (PFIC) or Alagille syndrome (ALGS)
- Patient needs treatment for pruritus due to PFIC or ALGS
- Patient is a resident of the United States (including its territories)
- Patient has financial need based on income and can verify eligibility for assistance

## Patient Information *(to be completed by the patient or parent/guardian on the patient's behalf)*

| | | | | |
|---|---|---|---|---|
| Name | | | | |
| Date of birth / / | | ❍ Male ❍ Female | | |
| Parent/guardian name *(if applicable)* | | Relationship | | |
| Address | | City | State | Zip |
| Home phone | Cell phone | Work phone | | |
| Email address | | Preferred contact ❍ Email ❍ Phone ❍ OK to leave message | | |
| Are you/your child a US citizen? ❍ Yes ❍ No If no, are you/your child a permanent US resident? ❍ Yes ❍ No | | | | |
| Total household income | | Number of people in your household | | |
| Do you have private prescription insurance coverage? ❍ Yes ❍ No | | Have you enrolled in Medicaid? ❍ Yes ❍ No | | |
| Are you enrolled in Medicare Part A and/or Part B or other government healthcare program? ❍ Yes ❍ No | | Medicare ID # *(if applicable)* | | |

## Patient or Parent/Guardian Declaration

I, as the patient or parent and/or guardian, understand that the Patient Assistance Program ("Program") is subject to the eligibility criteria stated above and that completing this application does not ensure that I will be accepted for this Program. I certify that all the information provided in this application, including household income, is complete and accurate. I understand that Program assistance can terminate if the Program becomes aware of information in my application that is incorrect. If I/the patient receive free product, I will not: (1) seek reimbursement for it from any insurer, health plan, or government program; (2) seek to have this prescription or any associated cost counted as part of my out-of-pocket cost for prescription drugs; and (3) sell, transfer, or otherwise divert free product provided to me from the Program. I understand that the Program provides free product for up to one year with the opportunity to reenroll. If my income or health insurance coverage changes, I will immediately notify ALBIREO ASSIST® at 855-ALBIREO. I agree to provide Albireo proof of my income if requested. I understand that Albireo may revise, change, or terminate the Program at any time without notice and the Program is not insurance.

We are collecting personal information in order to fulfill your request. The confidentiality of patient information is of utmost importance. For more information about Albireo's privacy practices, please visit https://www.ipsen.com/data-privacy/.

| | |
|---|---|
| Signature of Patient, Parent, or Guardian | Date / / |

**By fax:** 866-853-0479

**By email:** help@albireoassist.com

**Call 855-ALBIREO, Monday to Friday from 8 AM to 6 PM, or visit albireoassist.com for more information.**

The confidentiality of patient information is of utmost importance. Therefore, Albireo and its agents comply with all applicable federal, state, and local laws regarding patient privacy and confidentiality. For more information about Albireo's privacy practices, please visit www.albireoassist.com/privacy-policy.pdf.

Albireo
AN IPSEN COMPANY