EUFLEXXA Patient Assistance Program

The EUFLEXXA PAP provides EUFLEXXA at no cost to eligible patients. Eligible patients are U.S. residents who have no insurance coverage and whose household income falls at or below 300% of the U.S. Federal Poverty Level.

Checklist for submitting an application:

- Ensure all sections of the application are completed. Please make a copy before sending as no documents will be returned.
- Attach a copy of the most recent Federal Tax Return for all in the household. If the patient does not file taxes, please include a letter, signed by the patient stating this fact, along with other supporting documentation of income, including 1099, W2, disability/pension statement or pay stubs from two consecutive pay periods.
- Patient's signature and date are required on the application.
- Prescriber's signature and date are required on the application. Stamps are NOT acceptable.
- Fax the completed application and documentation to 1-866-959-9263.

Upon receipt of a completed application, the prescriber and patient will be notified of program eligibility. If the patient is eligible for assistance, the medication will be shipped to the prescriber's office. Eligibility shall be effective until the end of the calendar year.

Please contact the EUFLEXXA Patient Assistance Program with any questions or for additional assistance. We can be reached at 1-844-826-2851, Monday-Friday 9am-5pm EST.

EUFLEXXA Patient Assistance Program Application

Please fax to 1-866-959-9263

Phone: 1-844-826-2851

To qualify the patient must:

- Have no prescription drug insurance coverage or other coverage for EUFLEXXA
  AND
- Be a resident of the fifty U.S. States, the District of Columbia, Puerto Rico, or the U.S. Virgin Islands
  AND
- Have a household income below 300% of the US Federal Poverty Level

PATIENT INFORMATION

Patient Name:			
Patient Address:			
City:		State:	Zip:
Patient Phone #:	Date of Birth: / /		Gender:
Last Four Digits of Social Security #:			
Number of Individuals in the patient's household:			
Annual income of patient's household (all income sources, including, but not limited to, Social Security Benefits, Wages, Interest/Dividends, Pensions, Unemployment Compensation):			
Do you have any government or private insurance coverage for prescriptions?	☐ YES	☐ NO	
If yes, please indicate type of insurance (Medicare, Medicaid, State, Medicare Part D, Employer, Private Policy, Other, explain)			
Are you a resident of the fifty U.S. States, the District of Columbia, Puerto Rico, or the U.S. Virgin Islands?	☐ YES	☐ NO	

AUTHORIZATION FOR PAP PARTICIPATION AND DISCLOSURE OF PATIENT INFORMATION I understand that any assistance in the form of product at no cost is contingent upon my ability to meet the eligibility criteria for the EUFLEXXA Patient Assistance Program ("PAP") as determined by Ferring Pharmaceuticals Inc. ("Ferring") or third parties contracted by Ferring. I agree that Ferring does not have any obligation to provide PAP services to me and I waive any and all liability of Ferring in the provision of PAP services. I understand that by completing this form, I am not guaranteed eligibility to receive medication at no cost from the PAP. In the event I am eligible for the PAP, I acknowledge that this assistance is temporary and may be asked to reapply at designated intervals as determined by Ferring. I also understand that the PAP may be changed or discontinued at any time without any notice to me and at such time the PAP services will no longer be provided. I agree that I will not seek reimbursement for EUFLEXXA from any government program, health plan, or other third party insurer. If I am a member of a Medicare Part D plan, I will not seek to have this prescription or any cost associated with it counted as part of my out-of-pocket cost for prescription drugs. I certify that the information I have provided in this form is accurate and complete. I agree that I will notify the PAP if my insurance or financial situation changes. If I am eligible for participation in the PAP I authorize Ferring to forward this prescription to a dispensing pharmacy on my behalf.

I understand that the purpose of this authorization ("Authorization") is to give my permission for the disclosure and use of my protected health information to the extent it is required under state and federal law. I request and authorize my healthcare providers and healthcare insurers that have provided treatment, payment or services to me to disclose any information regarding my health, treatment, and coverage that pertains to payment for medication to the EUFLEXXA Patient Assistance Program, Ferring Pharmaceuticals Inc., its affiliates, or contracted third parties for the following purposes: (i) to determine eligibility for the EUFLEXXA PAP, (ii) if necessary, to account for and assist with my withdrawal from the PAP and/or transfer to a separate private or public payer program, (iii) to administer, evaluate, and maintain the high quality of the PAP; and (iv) for Ferring's internal business purposes, including quality control and research. I understand that once the PAP receives my health information, it may communicate with my health care providers and insurers to determine PAP eligibility. I understand that I am not required to sign this Authorization and that no health care provider or insurer will condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization. However, I understand that if I do not sign this Authorization, I cannot take part in the PAP (should I qualify I understand that I may cancel this authorization at any time by writing to the EUFLEXXA Patient Assistance Program as well as by notifying my health care providers and insurers. If I cancel this Authorization, I can no longer participate in certain aspects of the PAP. Once the PAP receives and processes my cancellation request, the PAP will not use my health information going forward. I understand that cancelling the Authorization will not affect any use of my health information that occurred before my request was processed. This authorization shall be valid for 5 years from the date of the signature on this form (unless a shorter period is prescribed by state law).

I understand that, unless otherwise restricted by state law, my health information released under this Authorization is subject to re-disclosure by the EUFLEXXA PAP and will no longer be protected by HIPAA.

Patient Authorization:	Date:

EUFLEXXA Patient Assistance Program Application

Please fax to 1-866-959-9263

Phone: 1-844-826-2851

PRESCRIBER INFORMATION

Prescriber Name:			
Prescriber Address:			
City:		State:	Zip:
Office Phone #:	Office Fax #:		
Office Contact Name:			
State License #:	State where Licensed:	NPI#:	

PRESCRIPTION INFORMATION

UNILATERAL	BILATERAL
☐ EUFLEXXA® (1% sodium hyaluronate)	☐ EUFLEXXA® (1% sodium hyaluronate)
Directions: Inject 1 EUFLEXXA syringe into affected knee weekly for 3 weeks.	Directions: Inject 1 EUFLEXXA syringe into each knee weekly for 3 weeks.
Quantity: 3 Refills:	Quantity: 6 Refills:

I certify that the information provided in this application is complete and accurate to the best of my knowledge, that the product ordered hereunder is medically necessary for this patient, and that I will be supervising the patient's treatment. I understand and certify that all units of any product shipped to me pursuant to this application will be provided to the above-named patient only, for his or her treatment, and will not be sold or otherwise distributed and that no patient or third party (including, but not limited to, Medicare and any other governmental programs) shall be charged for such product. Additionally, no units of this product will be submitted for Medicare, Medicaid or any public or private third party reimbursement, or returned for credit. I understand eligibility under this program is subject to the EUFLEXXA Patient Assistance Program's ("PAP") approval and the patient's continuing compliance will all eligibility requirements, as set by Ferring Pharmaceuticals Inc. ("Ferring"). I agree to allow the PAP or its authorized agent(s) to review the medical, financial and insurance records for this patient at any time for the purposes of verifying the patient's eligibility status for the program and the patient's receipt of any product(s) provided to him or her through the program. I have received a signed Patient Authorization to Disclose Protected Health Information from the above-named patient to Ferring, and contractors designated by Ferring.

I authorize the PAP, its affiliated companies, or its subcontractors to forward this prescription to a dispensing pharmacy on behalf of myself and my patient. This form should not be tampered with or revised in any way. Only originals with ink signature will be accepted.

PRESCRIBER SIGNATURE: _____ **DATE:** _____

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