NextSource CARES
Patient Assistance Program
80 SW 8th Street, Suite 2660
Miami, FL 33130
PH: (855) 672-2468 option 2
Fax: (855) 764-8774

Patient ID No. _____

About this program: The NextSource CARES Patient Assistance Program is designed to provide Gleostine® (Lomustine) Capsules to patients for whom a medical need is established, who cannot afford the cost of therapy and have no other reimbursement options that would enable them to purchase the Gleostine® (Lomustine) Capsules.

Instructions for Application

Patient Eligibility: Can I apply to this program? (You must meet all of these requirements).

- My doctor has prescribed a NextSource Biotechnology drug
- I am a permanent resident of the United States (I do not live outside of the 50 U.S. States)
- I am uninsured and/or my insurance does not cover my medication
- My total GROSS (before deductions) yearly household income is equal to or less than four (4) times the Federal Poverty Level. (Visit https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines for information on Federal Poverty Level guidelines)
- If insurance does cover medication but out-of-pocket costs are still high, please detail insurance and out of pocket costs under “Drug Coverage/Insurance Information”

How do I apply?

IMPORTANT: Patient must meet all program eligibility requirements to receive Gleostine® (Lomustine) capsules at no cost from NextSource CARES.

The following items MUST be included in the NextSource CARES Patient Assistance Program application for request processing:

Patient:

- ❑ Patient Information section of the application
- ❑ Completed and signed Patient Authorization for Use and Disclosure of Personal Health Information Form
- ❑ Drug Coverage/Insurance Information section completed
- ❑ Proof of Income

Physician

- ❑ Physician Section of the Application Form
- ❑ **Please attach/include both: 1) Copy of Prescription; 2) Patient Medication History (current medications, allergies and existing conditions)**

What are examples of Proof of Income documents?

- **TWO** most current paycheck stubs or earning statements for all working members of your household
- Last year’s federal Individual Income Tax Return (1040)
- Social Security Income Yearly Benefit Statement, pension, and other income statements
- Most recent W-2 or 1099 forms
- Unemployment Benefit Statements

Please Note: We do not accept bank statements as proof of income

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Patient Information (All Fields Required)

*Patient Name: *(Last) _____ *(First) _____ *(MI) _____

❑ Male ❑ Female *DOB: *MM _____ *DD _____ *YYYY _____ *SS#: _____

*US Resident: ❑ Yes ❑ No

*Address (PO Box not acceptable): _____

*City: _____ *State: _____ *Zip: _____

*Home Phone: _____ Cell Phone: _____

Email: _____

*Current Annual Household Income (Total combined yearly income for all family members): _____

*Number of family members in household supported by above income: _____

Drug Coverage/Insurance Information (All Fields Required)

*Do you have Medicare? ❑ Yes ❑ No Check all that apply: ❑ Part B ❑ Part D

- Current Status: ❑ Enrolled ❑ Denied ❑ Pending ❑ Appeal Pending ❑ Appeal Denied
- Supplemental Insurance? ❑ Yes ❑ No
- Insurer Name: _____

*Do you have coverage through a state Medicaid Program? ❑ Yes ❑ No

- Current Status: ❑ Enrolled ❑ Denied ❑ Pending ❑ Appeal Pending ❑ Appeal Denied

*Private Insurance: ❑ Enrolled ❑ Denied ❑ Pending ❑ Appeal Pending ❑ Appeal Denied

- If enrolled, insurer name: _____
- Plan name/ID/Group/Bin#: _____
- Total out of Pocket/Co-Pay (per Cycle): _____

Other (Please specify uninsured/underinsured details): _____

_____

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Patient Authorization for use and disclosure of Personal Health Information (All Fields Required)

By my signature below, I confirm that I am a resident of the US and that I understand and that I authorize NextSource CARES and any entity that may be contracted to be the Program administrator of NextSource CARES ("Administrator"), to receive and to have access to the following information: (1) information contained in this application; (2) information on the prescription medications that my Healthcare provider has provided or will provide me; and (3) other information that NextSource CARES or the Administrator may obtain about me in operating and administering the NextSource CARES Program (the "Information").

By my signature below, I further authorize NextSource CARES to use the information in the following manner: (1) to review my application and to contact me or my health care provider, as necessary, to conduct such review; (2) for purposes relating to the operation and administration of the NextSource CARES Program; and (3) for NextSource CARES' internal purposes involving patient assistance programs and charitable programs generally. I understand that this information will not be shared with other parties, but that certain non-indentifiable portions of the information (for example, general location, age, gender) may be shared with other parties for purposes of operating or analyzing NextSource CARES. I understand that I have the right to revoke this Authorization at any time by sending written notice to NextSource CARES at the address set forth on this application. If I revoke this Authorization, I will no longer be eligible for the services provided by the NextSource CARES Program. Canceling this authorization will prohibit disclosures of my personal information after the date the cancellation letter is received and processed, but will not affect disclosures made before that time.

I authorize any pharmacy and/or health care provider who is in possession of my health information to use and/or disclose to NextSource Cares and the Administrator all information relating to my participation in the Program. I understand that if my information is disclosed in this manner by a pharmacy or health care provider federal privacy laws may no longer protect the information from further disclosure.

I certify that the information I have set forth in this application is true, correct, and complete and that I meet all of the eligibility requirements of the NextSource CARES Program. I certify that I will not submit any claims to any insurance plan or program for the Gleostine I receive under the NextSource CARES Program. I agree to abide by the rules, procedures and conditions of this program. I understand that eligibility under the NextSource CARES Program is subject to approval by NextSource CARES and/or the Administrator, and that application to the NextSource CARES Program does not guarantee inclusion in the NextSource CARES Program. I understand that the NextSource CARES Program may be changed or terminated at any time without prior notice.

*Signature of Patient/Guardian/Patient Representative: _____

*Date: _____

*Patient Name (please print): _____

Name of Guardian/Patient Representative (if applicable): _____

Relationship to patient: _____

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Physician/Prescriber Information: (All Fields Required)

*Prescriber Name: *(Last) _____ *(First) _____ *(MI) _____

Specialty: _____

*Business/Facility Name: _____

*Address: _____ *City: _____ *State: _____ *Zip: _____

NPI: _____ DEA: _____

*State License Number: _____

*Primary Office Contact (Pt. Advocate/Social Worker): *(Last) _____ *(First) _____ *(MI) _____

*Phone: _____ *Fax: _____

*Email: (Status updates will be emailed to email on file) _____

Shipping Information (PAP require Gleostine to be shipped to physician/prescriber's office or a licensed pharmacy):

Attention to: (Last) _____ (First) _____ (MI) _____

Business/Facility Name: _____

Shipping Address: City/State/Zip _____

❑ (Ship Gleostine to Physician/Prescribers address listed above)

Gleostine ® (Lomustine) Capsules: (Note: This is not a valid prescription)

*Dose/Frequency: _____

*Estimated Duration of Therapy: _____

*Diagnosis: _____

Prescriber Certification and statement of medical necessity:
I certify that, to the best of my knowledge, the patient for whom this drug is requested meets the foregoing eligibility requirements and has a medical need for Gleostine® (Lomustine) Capsules. I agree that these medications will not be offered for sale, trade, or barter. Additionally, no claim for reimbursement will be submitted concerning these medications to Medicare, Medicaid, or any third party, nor will any medications be returned for credit. I further agree to permit NextSource CARES, upon reasonable notice to me, to audit my records to substantiate that drugs requested through this program were distributed at no charge, and that no insurance or reimbursement claim has been submitted with respect to such drug.

*Physician Signature: _____

*Date: _____

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NextSource CARES Patient Assistance Program Policy

1. Overview. The NextSource CARES Patient Assistance Program is designed to provide Gleostine® (Lomustine) Capsules to patients for whom a medical need is established, who cannot afford the cost of therapy and have no other reimbursement options that would enable them to purchase the Gleostine® (Lomustine) Capsules.

2. Definitions. For the purpose of this Policy Statement and the NextSource CARES Patient Assistance Program, the following definitions shall apply:

   "Patient": One on whose behalf an application has been submitted for Benefits under NextSource CARES Patient Assistance Program.
   "Applicant": A person who submits an application for Benefits under the Program.
   "Beneficiary":An Applicant whose application has been granted in full or part by NextSource CARES.
   "Benefits": The Gleostine® (Lomustine) Capsules that are the subject of the NextSource CARES Patient Assistance Program.
   "You": The Applicant and/or a Beneficiary, as appropriate from the context of this use.

3. Signatures Required. In order to be considered for Benefits under the NextSource CARES Patient Assistance Program, both You and the treating physician must complete and sign the appropriate sections of the application form. If the Patient is under 18, the Patient and his or her parents shall jointly submit and execute the application. Regardless of the age of the Patient, if any person described in the following clauses exists, all such persons must join in submitting and executing the application:

   a) any person that has legal custody or guardianship over the Patient; or
   b) any person that has the legal right/power to act on behalf of the Patient; or
   c) any person that claimed (or can claim) the Patient as a dependent on his/her most recent (or next) federal income tax return.

   At the request of NextSource CARES, a person described in subparagraphs (a) – (c) of this paragraph may be required to provide proof of his or her relationship to the Patient. We reserve the right to request information that supports the financial status of family members other than the Applicant.

4. Access to Information. Your application for Benefits must allow access to the financial, medical and other information about You required pursuant to the application. In order for NextSource CARES to receive certain medical information about You in your application, the Health Insurance Portability and Accountability Act of 1986 and the related Privacy Rule, 45 C.F.R. Parts 160 and 164, (collectively "HIPAA"), requires NextSource CARES to obtain your written authorization. If You do not sign the authorization NextSource CARES cannot process Your application and You cannot participate in the NextSource CARES Patient Assistance Program.

5. Eligibility. For purposes of this Policy, the determination of whether a person can afford the Gleostine® (Lomustine) Capsules is considered with respect to the individual and, if applicable, family/household members and/or any other person having legal responsibility for the Patient (if the Patient is a minor or a dependent adult). The NextSource CARES Patient Assistance Program is intended for Patients who are financially disadvantaged and have no other reimbursement options that would enable the Patient to purchase Gleostine® (Lomustine) Capsules. Only those Patients whose household income falls below a certain percentage of the federal poverty level adjusted by family size are eligible for Gleostine® (Lomustine) Capsules at no cost.

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6. U.S. Residents Only. Only Legal U.S. Residents are eligible for Benefits under the NextSource CARES Patient

7. Limit on Supply. A maximum of one initial prescription fill and five prescription refills of Gleostine® (Lomustine) Capsules may be awarded to a Beneficiary for each application submitted. Treating physicians and Patients must reapply if additional supplies are required.

8. No Right to Assistance. Neither a Patient nor an Applicant for Benefits under the NextSource CARES Patient Assistance Program has a legal right to receive assistance from NextSource CARES. Any award of Benefits from NextSource CARES will involve the assessment of many criteria among potentially qualified Patients and Applicants. Therefore, we reserve the right to grant or deny an application, in whole or in part, on the basis of such criteria as we deem appropriate. In particular, the fact that an Applicant or Patient may be granted an award of Benefits at one time does not mean that the Applicant or Patient is entitled to or will be granted an award of Benefits at any time.

9. Distribution. NextSource CARES uses contracted partners for all of its distribution activities, including distribution of the Gleostine® (Lomustine) Capsules. NextSource CARES is not responsible for the activities of its contracted distributors and any delays in shipment or other problems that might occur with the delivery of the Gleostine® (Lomustine) Capsules is solely the responsibility of the contracted distributor. Gleostine® (Lomustine) Capsules will be shipped to the requesting physician's office and dispensed by the physician.

10. Drug Shortage. NextSource CARES will attempt to ensure that sufficient quantities of Gleostine® (Lomustine) Capsules are available to provide You with the amount of drug that You may be awarded under NextSource CARES Patient Assistance Program. In the event that a shortage of drug exists at any time during a period of time for which You have been awarded drug under the NextSource CARES Patient Assistance Program, NextSource CARES will give You written or verbal notice of that shortage.

11. Waiting Lists. NextSource CARES may receive numerous applications resulting in request for more Gleostine® (Lomustine) Capsules than is available to the program. Therefore, NextSource CARES may not be able to approve all applications for Benefits. Moreover, a waiting list of Applicants may accrue, which may delay processing applications until sufficient Gleostine® (Lomustine) Capsules become available to the program.

12. Right to Modify Benefit. We, during the time period of any award to Beneficiary, reserve the right to review the award and/or the Patient's medical and financial situation. Based on that review, we reserve the right to increase, decrease or terminate Benefits previously awarded to You.

13. Additional Restrictions. In the course of reviewing an application and/or administering an award of Benefits under the NextSource CARES Patient Assistance Program, we reserve the right to impose such other conditions and/or require that You provide such other in information and/or that You take such actions as we deem appropriate.

14. No Warranties. NextSource CARES does not make any warranties, either expressed or implied, concerning any aspect of the NextSource CARES Patient Assistance Program.

15. Termination of Program. The NextSource CARES Patient Assistance Program may be terminated at any time.

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Patient Eligibility for NextSource CARES Patient Assistance Program

Section 5 – Eligibility Patients whose annual household income (all household members income must be included) falls below a certain percentage of the federal poverty level are eligible for the NextSource CARES Patient Assistance Program for Gleostine® (Lomustine) Capsules for little or no cost. Please find below the income tables based on household income and family size of the 2023 HHS Poverty Guidelines that must be met to qualify for Gleostine® (Lomustine) Capsules at no cost.

400% of Federal Poverty Level			
Persons in Family or Household	**48 contiguous States & DC**	**Alaska**	**Hawaii**
1	$58,320	$72,840	$67,080
2	$78,880	$98,560	$90,720
3	$99,440	$124,280	$114,360
4	$120,000	$150,000	$138,000
5	$140,560	$175,720	$161,640
6	$161,120	$201,440	$185,280
7	$181,680	$227,160	$208,920
8	$202,240	$252,880	$232,560
For each person in household over 8 persons, Add	$5,140	$6,430	$5,910