SK life science navigator
a subsidiary of SK biopharmaceuticals

XCOPRI® (cenobamate tablets) CV
Patient Assistance Program (PAP)
Fax to: **877-436-4188** or Email to: **sknavigator@rxallcare.com**
Mail to: **50 Bearfoot Road Northborough, MA 01532**
Have questions on enrollment? Please call **866-756-2844** (866-SK-NAVIG)

Disclaimer: The patient has elected to enroll in the SK life science navigator Patient Assistance Program (PAP). Please read and complete form in its entirety. Once eligibility has been determined you will be notified. Completion of this form does not guarantee enrollment. Your healthcare provider will also be responsible for submitting the SK life science navigator Enrollment Form.

PATIENT SECTION

Name (First, Last): _____ Date of Birth (MM/DD/YYYY): _____ Gender: ❑ Male ❑ Female

Patient Address: _____ City: _____ State: _____ ZIP: _____

Home Phone: _____ Mobile: _____ Email: _____

Are you a US Resident? ❑ Yes ❑ No

Name of XCOPRI Prescriber (First, Last): _____ Location of XCOPRI Prescriber (City, State): _____

Caregiver Name (First, Last): _____ Caregiver Relationship: _____

Caregiver Phone: _____ Caregiver Email: _____

PROOF OF ANNUAL HOUSEHOLD INCOME

Estimated household income (all members) currently is $ _____ ❑ Monthly ❑ Annually

Number of People in the Household: _____

❍ Social Security Disability Income (SSDI): _____ From (MM/DD/YYYY): _____ To (MM/DD/YYYY): _____

❍ Supplemental Security Income (SSI): _____ From (MM/DD/YYYY): _____ To (MM/DD/YYYY): _____

❍ Aid from the Department of Public Welfare: _____ From (MM/DD/YYYY): _____ To (MM/DD/YYYY): _____

❍ Unemployment Benefits: _____ From (MM/DD/YYYY): _____ To (MM/DD/YYYY): _____

❍ Workers' Compensation Benefits: _____ From (MM/DD/YYYY): _____ To (MM/DD/YYYY): _____

❍ Dividends, Interest or Investment Accounts: _____ From (MM/DD/YYYY): _____ To (MM/DD/YYYY): _____

❍ Employment (myself and/or my spouse): _____ From (MM/DD/YYYY): _____ To (MM/DD/YYYY): _____

❍ Other (includes assistance from family, friends, charity, or church. Please specify the amount of financial assistance you receive, which may include percentage of rent, food, etc): _____

Insurance Type	Status	Effective Date	Indicate Primary (P) or Secondary (S)
Commercial	Approved/Denied/Waiting for Decision		
Medicaid	Approved/Denied/Waiting for Decision		
Medicare	Approved/Denied/Waiting for Decision		
Tricare	Approved/Denied/Waiting for Decision		
Healthcare Exchange	Approved/Denied/Waiting for Decision		
Other	Approved/Denied/Waiting for Decision		
Uninsured	Patient is not eligible for any public health insurance, which includes Medicare and Medicaid, or has been denied coverage by a third-party payer		

PATIENT ASSISTANCE PROGRAM (PAP) AUTHORIZATION:

I promise that any information, including financial and insurance information that I provide to the PAP is complete and true, and, unless I have said something different in this application, I have no insurance coverage for this product, which includes Medicaid, Medicare, or any public or private assistance programs or any other form of insurance. If my income or health coverage changes, I will notify SK life science navigator at 866-756-2844 (866-SK-NAVIG). I understand that SKLSI has the right to contact me directly to confirm receipt of medications. SKLSI may revise, change, or terminate this program at any time. For information on SKLSI's privacy practices, visit sklifescienceinc.com/privacy-policy.

SIGN HERE **Patient/Legal Guardian Signature:** _____ **Date:** _____

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XCOPRI®
(cenobamate tablets) C
12,5 • 25 • 50 • 100 • 150 • 200 mg

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Patient Assistance Program
Financial Hardship Letter
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Note: All patients must submit a Patient Assistance Program (PAP) Application in addition to this financial hardship letter. Patients are also required to sign a Patient Authorization. Submission of the PAP application and this letter does not guarantee approval for SK life science navigator Patient Assistance Program. Your healthcare provider will also be responsible for submitting the SK life science navigator Enrollment Form.

PATIENT INFORMATION				
First and Last Name:				
Address:		City:	State:	Zip:
Date of Birth:	Phone:	Email:		

CAREGIVER INFORMATION			
First and Last Name:		Relationship to Patient:	
Phone:		Email:	

PRESCRIBER INFORMATION			
First and Last Name:			
City:	State:	Phone Number:	

TOTAL HOUSEHOLD INCOME (monthly)

Income Type	**Amount** (monthly)
Patient Income	
Other Household Income	
Other Income	
Total	**$0**
If income is $0, please explain why:	

XCOPRI Copay	

PATIENT/HOUSEHOLD EXPENSES (monthly)
Disclaimer: common expenses have been pre-populated, but patients should include all other expenses (i.e., childcare, debt/loans, etc.)

	Expense	**Amount** (monthly)
Example	Rent	$1,000
1	Rent/Mortgage	
2	Utilities (i.e., electric, water, gas, phone/internet, etc.)	
3	Food	
4	Transportation (i.e., car expense, gas, taxis/Uber, etc.)	
5	Medical Insurance	
6	Medical Expenses (excluding XCOPRI®)	
7		
8		
9		
	Total	**$0**

Why should you/patient be considered for free product? Is there anything else SKLSI should consider?

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