US WorldMeds Patient Assistance Program (UPAP)
Administered by: Truax Patient Services
1112 Railroad Street SE • Suite #4 • Bemidji, MN 56601
Phone: (877) 438-9759 Fax: (877) 619-6574

Dear Applicant,

Thank you for your interest in the US WORLDMEDS Patient Assistance Program (UPAP). Enclosed you will find the application form you requested.

To participate in our program, it is important that you complete all the requested information and sign where indicated. Incomplete applications will not be processed until missing information is received.

PATIENT REQUIREMENTS:

- Must be a U.S. citizen or legal resident, with a valid Social Security Number.
  - Residents of Puerto Rico or other U.S. territories are **not** eligible.
- Must not have insurance coverage, either private and/or public.
  - Medicare Part D Applicants: If Part D does not allow or pay for any part of your medication, you will be viewed as having no insurance. **Being in the donut hole does not qualify.**
- Must provide a list of other medications you are currently on.
- Must be under the care of a licensed Healthcare Provider who is authorized to prescribe, dispense, and administer medicine in the U.S.
- Must complete and sign the PATIENT INFORMATION and PATIENT ELIGIBILITY sections on Page 3.
- Must have a total household income at or below 400% of the federal poverty level (FPL).
  - For more information on FPL in your state, please visit the Families USA website, https://aspe.hhs.gov/poverty-guidelines
- Must provide documentation of ANNUAL household income.

  Acceptable forms of documentation include **one of the following:**
  - Copy of most recently filed Income Tax Return (IRS Form 1040) or W-2
  - Copy of transcript received through submission of IRS 4506-T
  - Copy of most recent Social Security/Disability monthly check, award letter, benefit statement of 1099
  - Copy of Unemployment Determination letter
  - Certified letter stating you have no income in your total household

HEALTHCARE PROVIDER REQUIREMENTS:

1. Complete and sign the HEALTHCARE PROVIDER INFORMATION and REQUESTED MEDICATION sections on page 2.
   - The completed REQUESTED MEDICATION section will be accepted as a legal prescription.
     - If preferred, a prescription can be attached separately in place of completing the REQUESTED MEDICATION section.
2. Submit completed applications by utilizing one of the following methods.
   - **MAIL**: Truax Patient Services / 1112 Railroad St. SE STE #4 / Bemidji, MN 56601
   - **FAX:** (877) 619-6574
   - **EMAIL:** bwtruax@truaxpatientservices.com

You will be notified upon completion of our review and evaluation.

Medication will be mailed directly to the patient's address through Truax Patient Services Pharmacy unless viewed as a health risk. Please note, program rules are subject to change without notice. If you have questions or need further assistance, please call (877)-438-9759 or (218)-444-8217, between 9:00 AM and 5:00 PM Central Standard Time, Monday through Friday.

Sincerely,

US WORLDMEDS Patient Assistance Program (UPAP) Team

Please see the full Prescribing Information for LUCEMYRA at LUCEMYRA.com.

US WorldMeds®

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Prescriber Information

First Name: ____________________ Last Name: ____________________ ☐ MD ☐ DO ☐ PA ☐ NP ☐ PharmD

Facility Name: ____ NPI #: ______________

Street Address: ____

City: ____ State: __________ Zip: ____________

Phone Number: ________________________ Fax Number: ______________________________

Patient Diagnosis: ____

LUCEMYRA® *(lofexidine)*

The usual LUCEMYRA starting dosage is three 0.18 mg tablets taken orally 4 times daily during the period of peak withdrawal symptoms (generally the first 5 to 7 days following last use of opioid) with dosing guided by symptoms and side effects. It is recommended to discontinue LUCEMYRA with a gradual dose reduction over a 2- to 4-day period to mitigate LUCEMYRA withdrawal symptoms.

The following would be an example of the usual dosing of LUCEMYRA for a course of treatment:

LUCEMYRA 0.18 mg #96
Sig: Take 3 tabs p.o. QID Days 1-7
Take 2 tabs p.o. QID on Day 8
Take 1 tab p.o. QID on Day 9, then discontinue
May be taken with or without food.

LUCEMYRA (BRAND)

96-Count_________

0.18 mg ___________

SIG # _____________

# of Refills ______

Prescriber Declaration

My signature below certifies that the person named on this form is my patient, and I represent that information I have provided about this patient is complete, accurate, and consistent with applicable privacy laws andregulations. I also certify that any medication received from UPAP is medically necessary for the patient named on this form, and will be used only for this patient. I further certify that the dose requested for this patient is appropriate for this patient's medical condition and complies with the Food and Drug Administration (FDA) dosing guidelines. To the best of my knowledge, this patient has no prescription insurance coverage, including Medicaid, Medicare, or other public or private programs. This medication will not be offered for sale, trade, or barter. I certify that no claim for reimbursement for any medication furnished under the UPAP will be submitted to the Medicare program, any state Medicaid program, any other healthcare benefit plan, or returned for credit. I understand that UPAP reserves the right to modify or terminate this program at any time. I understand that UPAP reserves the right to recall or discontinue the product at any time without notice.

SIGN HERE **Healthcare Provider Signature:** ____ **Date:** ______________

Please see the full Prescribing Information for LUCEMYRA at LUCEMYRA.com.

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PATIENT INFORMATION TO BE COMPLETED BY PATIENT OR LEGAL GUARDIAN

First Name: ______________________ MI: ______ Last Name: ______________________

Mailing Address: ____

City: ______________________________ State: __________ Zip: __________

Social Security #: ________ – ______ – ________ DOB: MM / DD / YYYY Phone #: ______________

Contact Person (if different from patient): ______________________ Phone #: ______________

Drug Allergies: ____

Medications currently on: ____

PATIENT ELIGIBILITY INFORMATION – Attach proof of annual household income *(Required)*

TOTAL ANNUAL HOUSEHOLD INCOME: $ ________________

(Include all annual income, wages, social security, pension, disability, interest earned on savings, etc.)

Household Size (number of persons living in the home): ____________

Are you currently enrolled in a Medicare Part D Prescription Drug Plan? ☐ Yes ☐ No

Do you have any public or private prescription drug coverage or are you in any benefit program that helps pay for your prescription drugs? ☐ Yes ☐ No

Have you received a final denial from the VA for prescription benefits, including exhausting all appeals? ☐ Yes ☐ No

Patient Certification and Authorization

I attest that the above information is complete and accurate. I attest that I have insufficient financial resources to pay for the prescribed therapy and that I have no other health insurance coverage for prescription drugs including but not limited to Medicare, Medicaid, employer/retiree-sponsored coverage, or enrollment in a state pharmacy assistance program. I acknowledge and agree not to submit an insurance claim or other claim for payment to any third-party payer (private or government) for the medication. By my signature, I authorize the release of the information about me and my medical condition to the US WORLDMEDS Patient Assistance Program (UPAP) and/or their agents and that once it is released it may not be protected by federal health privacy laws. I authorize TRUAX PATIENT SERVICES and/or their agents to use and disclose such information for the assessment of my eligibility for and enrollment into UPAP and administration of UPAP, which may include contacting my insurer, public funding programs, social workers, advocacy organizations, healthcare providers, or other persons or entities UPAP may deem appropriate to release all medical records or requested information bearing on my eligibility to and benefits under the program. My signature certifies that the medication received from UPAP will not be resold nor offered for sale, trade or barter and will not be returned for credit. Additionally, I agree that at any time during my enrollment, UPAP may contact me to request additional documentation to authenticate the statements made on my application. UPAP and/or their agents agree not to disclose any information to any third party except as authorized by me or as required by law. I understand and acknowledge that this assistance is temporary and that this program may be changed or discontinued at any time without notice.

Patient's Signature : ______________________________ **Date:** __________

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION:

This document authorizes the disclosure and/or use of individually identifiable health information, set forth below, consistent with federal law concerning the privacy of such information.

USE AND DISCLOSURE OF HEALTH INFORMATION:

I hereby authorize the use or disclosure of my health information as follows:

- Persons/organizations authorized to use or disclose the information: My insurer, pharmacist, physician, or other health care provider.
- Persons/organizations authorized to receive the information: US WORLDMEDS Patient Assistance Program (UPAP) and authorized employees. Truax Patient Services and its authorized employees.
- Purpose of requested use or disclosure: To (1) confirm my eligibility to receive medications under the Program, (2) facilitate my participation in the Program, and (3) administer the Program.
- This Authorization applies to the following information: Information about my prescribed medications and medical condition, including prescriptions.
- This Authorization expires one (1) year after I cease to participate in the Program.

NOTICE OF RIGHTS AND OTHER INFORMATION:

I may refuse to sign this Authorization, but such refusal would cause me to be ineligible to participate in the Program.

I may revoke this Authorization at any time by calling (877) 438-9759 and mailing a written revocation, signed by me or on my behalf, to Truax Patient Services at 1112 Railroad St SE STE#4, Bemidji, MN 56601. My revocation will be effective upon receipt, but will not be effective to the extent that the requestor or others have acted in reliance upon this Authorization. Revocation of the Authorization would cause me to be ineligible for further participation in the Program.

I understand that once health information about me has been disclosed in reliance upon this Authorization, the information may no longer be protected under federal privacy laws and may be further disclosed.

I have a right to receive a copy of this Authorization and may request a copy by calling (877) 438-9759 or mailing a written request to Truax Patient Services at 1112 Railroad St SE STE#4, Bemidji, MN 56601.

SIGN HERE **Patient's Signature :** ______________________________ **Date:** __________

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