HLS Therapeutics

Enrollment Application for the HLS Therapeutics' Patient Assistance Program

P.O. Box 29217, Phoenix, AZ 85038-9217
Phone: 1-844-457-8721 Fax: 800-803-3105
hlstherapeutics.com

Dear Patient and Health Care Professional:

Thank you for your interest in the HLS Therapeutics' Patient Assistance Program. To be eligible for the HLS Therapeutics' Patient Assistance Program, patients must:

- Be a U.S. resident
- Meet the income requirements ***and***
- In general, have no private or public prescription coverage for the product

Patient Assistance available for: Clozaril® (Clozapine)

Checklist for submitting application:

- **Patient to** complete Sections I and II
- **Patient to** attach current proof of income as outlined in Section I
- **Patient to** sign and date Section III
- **Patient to attach copy of insurance card**
- Health Care Professional to sign and date Sections IV and V
- **Send** the completed application and all documentation to the fax # or address above

SECTION I Patient Information and Income

First Name _____ Last Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email _____

US Resident: ☐ Yes ☐ No **Gender:** ☐ M ☐ F **Veteran:** ☐ Yes ☐ No **Disabled:** ☐ Yes ☐ No
(Status as deemed by Social Security)

Social Security/ID # _____

Date of Birth _____ Product _____

FINANCIAL INFORMATION: Attach a copy of your household's most recent year tax returns (1040, 1040EZ, 1099, etc)

Do not send original documents with your application.

Total # of people in the home including self (include ***all*** those living with you)

☐1 ☐2 ☐3 ☐4 ☐5 ☐6 or more # of children ____ # of adults ____

List all sources of Gross Monthly income:

Salary/Wages (all sources)	$ _____
Pension/Retirement	+$ _____
Social Security	+$ _____
Disability	+$ _____
Unemployment Benefits	+$ _____
Alimony/ChildSupport	+$ _____
Total Gross Monthly Household Income	=$ _____

SECTION II Insurance Information (Please include a copy of the front and back of your insurance card)

I have insurance from (check all that apply)

☐Medicare ☐Medicaid ☐VA ☐Private Drug Coverage ☐State Assistance ☐Health Exchange Plan ☐None ☐Other _____

SECTION III Patient Authorization (Please read and sign)

I give permission for my health care professional(s) and their staff to disclose my personal information, including information about my insurance, prescription, medical condition and health ("Health Information") to HLS Therapeutics ("HLS") so that HLS can determine if I am eligible for the HLS Therapeutics' Patient Assistance Program ("PAP"); I also grant permission to HLS to send me information about PAP and other programs that might help me pay for my medicines; send my information to other programs that might help me pay for my medicines; and ask me for financial, insurance and/or medical information and share my information as required or permitted by law. I give permission to HLS to use information on this application and any other information I give to HLS for these same reasons. I also give HLS permission to share my health information and other information with people and companies that work with HLS; government agencies, including the Centers for Medicare and Medicaid Services; insurance companies, including Medicare Part D plans; my health care professional(s) and other people, or institutions who are involved in my health care, such as pharmacies and hospitals, and other organizations that might help me pay for my medication. I promise that any information, including financial and insurance information that I provide to HLS are complete and true and unless I have said something different in this application, I have no drug insurance coverage, 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 call the PAP at 1-844-457-8721. I know that HLS may change or end the PAP at any time. I know that if I do not sign this form, I will not be able to participate in the PAP, but this will not affect my ability to get medical care, seek payment for this care or affect my enrollment or eligibility for insurance. I know that I can cancel this permission at any time by calling the PAP at 1-844-457-8721. If I do, then I will not be able to stay in the PAP. I understand I have the right to receive a copy of this form.

Patient or Legal Guardian Signature: _____ Date: _____

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SECTION IV Health Care Professional (HCP) Information (To be completed by HCP)

First Name _____ Last Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

Email _____

DEA/State License # _____ NPI # _____

Office Contact _____ Office Contact Phone Number (if different than above) _____

SECTION V HCP Authorization (Read and sign)

My signature below certifies that the person listed above is my patient. I acknowledge that I have assisted the patient in enrolling in the HLS PAP exclusively for purposes of patient care and not in consideration for, expectation of, or actual receipt of remuneration of any sort. I also agree that HLS has the right to contact the patient directly to confirm receipt of medications, and I understand that HLS may revise, change, or terminate this program at any time. Finally, to the best of my knowledge, the patient listed above meets HLS eligibility criteria for the PAP.

Health Care Professional Signature: _____ Date: _____