EVZIO (naloxone HCl injection) 0.4 mg auto-injector

kaléo Cares

Patient Assistance Program

Please fax* completed forms to: 1-800-943-1730

**Faxes must be sent from prescriber's office.*

Kaléo understands the importance of having emergency medications available to patients but recognizes that some patients may have financial difficulties that prevent them from obtaining these needed medications. The kaléo Cares Patient Assistance Program is here to help those patients who are experiencing financial difficulties.

To be eligible for assistance to receive EVZIO at no cost you must:

- Be a legal US resident.
- Not have any drug coverage.
- Not be eligible for Medicaid or Medicare.
- Have an annual household income equal to or less than 150% of the Federal Poverty Level.

Other terms and conditions may apply, and we reserve the right to discontinue the program at any time. This is not insurance.

Section 1: Patient Information		
First Name	**Last Name**	
Street Address (**Cannot** be PO Box)		
City	**State**	**Zip**
Primary Phone	**Secondary Phone**	
US Resident ☐ **Yes** ☐ **No**	**SSN (or Green Card or Visa Number)**	
Gender ☐ **Male** ☐ **Female**	**Date of Birth**	

SECTION 2: Insurance and Income Attestation	
Do you have prescription drug coverage? ☐ **Yes** ☐ **No**	**Number of Dependents** (Total Number of People in Household)
Are you eligible for Medicaid or Medicare? ☐ **Yes** ☐ **No**	**Annual Household Income***
All medication will be shipped directly to patient.	***Note: Patient may be required to provide proof of income.**

I declare and affirm that the information provided on this application form is true and accurate. I give consent to the Program to disclose my enrollment in the Program as needed to comply with legal and regulatory obligations. I agree to notify the Program immediately if my prescription drug coverage changes in any way before I receive a prescription or a refill.

Patient's Signature	**Date**

Section 3: Patient Privacy and Consent

The information you provide will be used by kaléo, the kaléo Cares Patient Assistance Program, and parties acting on their behalf to determine eligibility, to manage and improve the kaléo Cares Patient Assistance Program, products and services, to communicate with you about your experience with the kaléo Cares Patient Assistance Program, and/or to send you materials and other helpful information and updates relating to kaléo programs.

By signing below, I affirm that my answers and my documented income are complete, true and accurate to the best of my knowledge.

I understand that:

- Completing this enrollment form does not guarantee that I will qualify for the kaléo Cares Patient Assistance Program.
- Kaléo may verify the accuracy of the information I have provided and may ask for more financial and insurance information.
- Any medicines supplied by kaléo Cares Patient Assistance Program shall not be sold, traded, bartered, or transferred.
- Kaléo reserves the right to change or cancel the kaléo Cares Patient Assistance Program, or terminate my enrollment, at any time.
- The support provided by this program is not contingent on any future purchase.

I certify and attest that if I receive medicine(s) provided by kaléo through the kaléo Cares Patient Assistance Program:

- I will promptly contact kaléo if my financial status or insurance coverage changes.
- I will not seek reimbursement or credit for the medicine(s) from my prescription insurance provider or payor for any costs of medications.
- I will not seek to have this medicine or any cost from it counted in my out-of-pocket expenses for prescription drugs for any payor.
- I will notify my insurance provider of the receipt of any medicines through the kaléo Cares Patient Assistance Program.

I may refuse to sign this consent. If I refuse, I will not be able to participate in the Program, but it will not affect my ability to obtain medical treatment, my ability to seek payment for treatment, or affect my insurance enrollment or eligibility for insurance benefits.

I certify that the information on this form is accurate and complete to the best of my knowledge.

Patient's Signature	**Date**

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Patient Name		**Date of Birth**
Allergies		
Other Medications		
Section 4: Healthcare Provider Information		
Prescriber First Name		**Prescriber Last Name**
Street Address		
City	**State**	**Zip**
Office Contact Name	**Office Phone**	**Office Fax**
State License	**NPI**	**DEA**
Section 5: Prescription		

EVZIO™
(naloxone HCl injection) 0.4 mg auto-injector **Directions** _____ **Quantity** _____ **Refills** _____

Diagnosis **ICD-9** _____ **Other** _____

Date	**Anticipated Start Date**

I certify that this EVZIO prescription fits the indication and is medically appropriate for this patient. I affirm that the patient is not eligible for Medicaid or Medicare and the information provided by the patient on this application form is complete and accurate to the best of my knowledge. I give consent to the kaléo Cares Patient Assistance Program, its affiliated companies, or its subcontractors to forward this prescription to a dispensing pharmacy on behalf of myself and my patient.

Prescriber's Signature

Dispense as Written _____ Substitution Allowed _____

NY prescribers – *please submit prescription on an original NY State prescription blank;*
TN prescribers – *quantity must be written in both numerals and words. Example: 3 (three) doses*

For assistance with any questions, call **1-844-MYEVZIO** (1-844-693-8946) • Monday through Friday from 8 AM to 7 PM EST
For additional information on EVZIO, please visit our website **EVZIO.com**