PATIENT ASSISTANCE PROGRAM ENROLLMENT APPLICATION

Dear Patient:

Thank you for your inquiry with regard to participating in the Galderma Patient Assistance Program. Please follow the instructions below. If you have any questions, please contact us 855-431-3737.

Note: Maximum enrollment period **will not exceed two years.**

Instructions
Review the eligibility guidelines and complete the application with the assistance of your doctor.

Eligibility Guidelines

- Patient must be a legal resident of the United States;
- Patient must not qualify or be eligible for or enrolled in any private insurance with prescription coverage such as an HMO or PPO;
- Patient must not be enrolled or participate in Medicare Part D, Medicare, Medicaid, MediGap, VA, DOD or Tricare, or any other government-run or government sponsored health care program with a pharmacy benefit or where prohibited by law;
- Patient must not qualify for or be enrolled in any state and/or Federal assistance for prescription medications; and
- Patient's total household income must be below the income standards listed in the chart below:

Family Size	Gross Yearly Income	Gross Monthly Income
1	$23,540	$1,962
2	$31,860	$2,655
3	$40,180	$3,348
4	$48,500	$4,042
5	$56,820	$4,735
6	$65,140	$5,428
7+	$73,460	$6,122

Patient

- Patient Information: Name, Street Address (no PO Boxes), DOB, Telephone number, Social Security Number
- Complete household income with **ONE** of the following supporting documents, detailing household income:
  - Most recent U.S. **tax return;**
  - Letter from the **Social Security Administration** stating income for each member of your household;
  - Most recent **W-2s or 1099s** for each member of your household; or
  - Current **pay stub(s)**, for one month of employment **or** a letter from your employer(s), on letterhead, stating annual income. Include pay stub(s) or a letter for each actively employed member of your household.
- Patient or Legal guardian's signature and date

Practitioner

- Full practitioner information (with mailing address, phone and fax numbers, and office contact information)
- National Provider Identifier, DEA Number or State License number provided on Provider section of application
- Practitioner signature on application
- Please provide a prescription to accompany the patient enrollment application

Incomplete or incorrect applications will cause a delay in processing.
Please ensure all information is accurate before submitting.

The completed enrollment form, supporting documentation and signed prescription must be submitted to the following:

Galderma Patient Assistance Program
2730 S. Edmonds Lane, Ste. 300
Lewisville, TX 75067
Telephone: 855-431-3737 Fax: 855-431-3738

Once your application is processed, you will receive notification of your eligibility status via U.S. mail. If eligible, you will receive your product(s) via UPS shipment directly to your residence. If ineligible, a denial letter will be sent to you via U.S. Mail.

PATIENT ASSISTANCE PROGRAM ENROLLMENT APPLICATION

Patient Information

Last Name _____ First Name _____ Date of Birth _____

Street number and Name _____ Apt # _____ City _____ State _____ Zip Code _____

Telephone number _____ Alternate number _____ Social Security Number _____

Alternate Contact Name _____ Phone number _____

Patient is a legal resident of the US? _____Yes _____No Number of residents in household_____

Total annual household income including social security and pension benefits? $_____

By signing this Authorization, I authorize my health plans, physicians, and pharmacy providers to disclose my personal health information, including, but not limited to, information relating to my medical condition, treatment, care management, and health insurance, as well as all information provided on this form and any prescription ("Personal Health Information"), to Galderma Laboratories, L.P. — the Galderma Patient Assistance Program —and its representatives, agents, and contractors (collectively "Galderma") for the following purposes: (1) to establish my eligibility for Program benefits; (2) to communicate with my healthcare providers and me about my medical care; (3) to facilitate the provision of products, supplies, or services by a third party including, but not limited to specialty pharmacies; (4) to register me in any applicable product registration program required for my treatment; and (5) to contact me with branded support materials related to my treatment. I understand that I am entitled to a copy of this Authorization. I understand that I may cancel this Authorization at any time by mailing a letter requesting such cancellation to Galderma Patient Assistance Program, 2730 S. Edmonds Lane, Ste. 300, Lewisville, TX 75067, but that this cancellation will not apply to any information already used or disclosed through this Authorization.

By signing this Authorization, I affirm all of the following: (1) I am a legal resident of the United States; (2) I do not qualify nor am I eligible for private insurance; (3) I am not enrolled in Medicare Part D, Medicare, Medicaid, MediGap, VA, DOD or Tricare, or any other government-run or government sponsored health care program with a pharmacy benefit or where prohibited by law; (4) I do not qualify and do not participate in any State or Federal assistance for prescription medications; (5) my total household income is under 200% of the poverty level; (6) the prescription medication requested is for me; and (7) I will not sell, trade or use the medication for any other purpose then its intended and prescribed use.

Patient or legal guardian's sign _____ Date _____

Eligible Products

- ☐ Epiduo® (adapalene and benzoyl peroxide) Gel, 0.1%/2.5%,45gm
- ☐ Mirvaso® (brimonidine) topical gel, 0.33%
- ☐ Oracea® (doxycycline, USP) Capsules, 40 mg, 30-day or 90-day supply (recommended)
- ☐ SOOLANTRA® (ivermectin) Cream, 1%

Product substitutions are not allowed

Provider Information

Last Name _____ First Name _____ NPI _____

Street number and Name _____ Suite # _____ City _____ State _____ Zip Code _____

Telephone # _____ Fax # _____ Office Contact _____

Signature (No stamped signatures) _____ Date _____

Galderma Laboratories, L.P. provides prescription drugs under this charitable program only upon the written request of a licensed physician and only for the use of an identified patient with a medical need for the drug who cannot afford it. These drugs are not to be sold, traded, or used for any other purpose.