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KEVEYIS™
dichlorphenamide 50 mg tablets

KEVEYIS™ PATIENT ASSISTANCE PROGRAM

About the Patient Assistance Program

- The Patient Assistance Program allows qualified patients to obtain free medication. It is not a government program or insurance plan.
- If patients qualify, they may receive free medication for up to 12 months as long as they continue to meet the program requirements. Patients will be required to reapply annually.
- Medication will be sent directly to the patient's home or an alternate shipping address of his or her choice. All packages require a signature at the time of delivery.
- Medication is sent in a 30-day supply.

Program qualifications

A patient may qualify for the program if

- The patient does not have existing drug coverage for the prescribed product under any prescription drug benefit, including private insurance, Medicare, Medicaid, or other government insurance programs *or* the patient is in the 90-day waiting period for Medicare coverage, *or* the patient is a participant of Medicare Part D and has already spent 3% of his or her annual household income out-of-pocket this year on prescription medication, *and*
- The patient is a US resident, or has a Green Card or work visa, *and*
- The patient has an income at or below 600% of the federal poverty level *or* the patient has experienced a recent financial challenge due to circumstances such as changes in household income, loss of employment, changes in marital status, or changes in household number (*supporting documentation explaining changes in circumstance and new income will be required*)

Application instructions

If you think your patient qualifies for the Patient Assistance Program, please complete the following steps:

1. Complete the application on the next page with your patient
   - If the patient has no insurance, have your patient provide one of the following as proof of income:
     - A copy of last year's federal income tax returns for patient, spouse, and dependents, *or*
     - All income statements from jobs (W2 or 1099), *or*
     - Social security income yearly benefits statement
   - If the patient has financial hardship, have your patient provide proof of income *and* supporting documentation explaining the changes in circumstances.
2. Fax the completed and signed form to **1-855-423-8304**.

Please see the full Prescribing Information attached.

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dichlorphenamide 50 mg tablets

KEYS 2 CARE™ FROM ACCESS TO SUCCESS

PATIENT ASSISTANCE PROGRAM APPLICATION FORM

This form is to be filled out and signed by a healthcare provider and the patient. The completed form should be faxed to **1-855-423-8304**.
If you have questions, please call **1-855-611-3401**.

Please complete all fields to avoid any delays in processing.

Patient information

Name: _____ Date of birth: ____ /____ /____ (mm/dd/yyyy) Gender: ☐ Male ☐ Female
First Middle initial Last

Address: _____ City: _____ State: _____ ZIP: _____ Phone: (____) ____-_____

Prescriber information

Prescriber's name: _____ Phone: (____) ____-_____

NPI#: _____ Fax: (____) ____-_____

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

Prescription information

☐ Keveyis™ (dichlorphenamide) 50 mg tablets Qty: 30-day supply

Sig: _____ Refills: _____

Prescriber's signature: _____ **Date:** _____

Social Security number

_____-_____-_____ If you do not have a Social Security number you must provide one of the following:

☐ Green Card number: _____

☐ Confirmation letter from the government stating a US Green Card application has been submitted

☐ Work visa number: _____

Income

Number of people in household (*include patient, spouse, and dependents*): _____

Total combined household income (*include patient, spouse, and dependents*): $_____monthly **or** $_____yearly

NOTE: *Patient will need to provide proof of income.*

Insurance

Does the patient have any form of prescription drug coverage?

☐ Employer-furnished or private-drug coverage ☐ Medicaid ☐ Medicare Part A ☐ Medicare Part B ☐ Medicare Part D
☐ VA or military benefits ☐ State assistance program for medicine

PATIENT ATTESTATION AND AUTHORIZATION FOR RELEASE OF INFORMATION

The Keveyis Patient Assistance Program must have the patient's authorization to determine eligibility for patient assistance and to conduct insurance research. By signing below, I authorize Taro and/or its affiliates, and Diplomat Pharmacy, Inc., and/or its affiliates ("Diplomat") to contact me, my insurer(s), and physicians, and authorize my insurer(s) to disclose to Diplomat my Protected Health Information, as defined within 45 C.F.R. § 160.103, including but not limited to medical records and treatment, health insurance coverage, my name, address, telephone number, insurance plan, and/or group numbers. Furthermore, I authorize Diplomat to provide the insurer(s), including Medicare, with my name, date of birth, Social Security number, diagnosis, insurance information, or other relevant information about me. By signing below, I also attest that the financial information I have provided is complete and accurate and agree that Diplomat may verify this information. I understand that my choice about whether to sign this Attestation and Authorization for Release will not change the way my healthcare providers or insurer(s) treat me. I understand that I may cancel (revoke) this Authorization for Release at any time by contacting Diplomat or Exelixis at **1-855-611-3401**. I understand that once my Protected Health Information is disclosed, it will no longer be protected by federal privacy law and may be redisclosed. I acknowledge that Taro reserves the right to change or revoke this program at any time. By signing below I authorize Diplomat to contact me directly about available assistance programs, treatments and therapies, and/or reimbursement and access-related information.

Patient's signature: _____ **Date:** _____
(If patient cannot sign, patient's legally authorized representative must sign)

Legally authorized representative's name: _____ **Relationship:** _____

Please see the full Prescribing Information attached.

Taro Pharmaceuticals U.S.A., Inc.
3 Skyline Drive, Hawthorne, NY 10532