781 Chestnut Ridge Rd
Morgantown, WV 26505
Phone: 800.395.3376
Fax: 304.554.4713 / 800.835.4329

Policies and Procedures

Thank you for your interest in the Mylan EpiPen 2-Pak® Auto-Injector Patient Assistance Program ("MEPAP").
Enclosed you will find the application form you requested.

To participate in the program, you must not carry any type of prescription insurance coverage, and you must meet the financial need eligibility criteria set forth below.
It is important that you and your physician complete all requested information, and sign the application where indicated.
Incomplete or incorrect applications will delay the application process, so please ensure all information provided is correct.

Patient

- The patient must be a U.S. citizen or a legal resident living in the United States.
- The patient must not have prescription insurance coverage through Medicaid, Medicare Part D, a qualified health plan purchased on a state-based, partnership, or federally-facilitated Exchange, or any other public or private program or insurer. Verification documents will be required.

  Approved Documents: Denial Letter, Termination Statement, Statement from Physician, Nurse, or Patient Advocate, Statement from applicant that is notarized with a seal, etc.
- The patient's gross yearly household income must fall below 200% of the current Federal Poverty Guidelines, based upon family size.
- Verification documents will be required.

  Approved Documents: 1040, 1040ez, W2, 4506-T, SSI Statement, Disability Statement, Statement from Physician, Nurse, or Patient Advocate, Statement from applicant that is notarized with seal, etc.

Physician

- The physician must complete, sign and submit the MEPAP Application acknowledging that the patient is in need of assistance.
- The product will be shipped from the MEPAP to the physician's office to be dispensed to the approved patient free-of-charge. Product will not be shipped to a patient's home or to a P.O. Box.
- The physician must certify that he/she will call the Mylan EpiPen 2-Pak® Auto-Injector Patient Assistance Program at 800.395.3376 if the patient's prescription insurance coverage changes, if the patient's dosage changes, or if the patient discontinues therapy.
- The physician must certify that he/she will not submit a claim for any payment for the free product or resell, trade, barter or return for credit any free product received from MEPAP.

Completed forms and required documentation for the Mylan EpiPen 2-Pak® Auto-Injector Patient Assistance Program should be mailed or faxed to:

Mylan EpiPen 2-Pak® Auto-Injector Patient Assistance Program
781 Chestnut Ridge Rd
Morgantown, WV 26505

Fax: 304-554-4713

Additional information about the Mylan EpiPen 2-Pak® Auto-Injector Patient Assistance Program is available by calling 800.395.3376.
Mylan reserves the right to discontinue or modify this program at any time.

If the applicant is approved for the program, medication will be shipped to the physician's office to be dispensed to the patient free-of-charge. Once approved, the applicant will be eligible to receive replenishment medication (as prescribed by the patient's physician) for up to one year. A Replenishment Authorization Form will need to be filled out by the patient's physician and faxed to Mylan EpiPen 2-Pak® Auto-Injector Patient Assistance Program in order to receive the next replenishment. Please note that replenishment requests will be considered on an as needed basis. Please check with your healthcare professional(s) prior to placing any replenishment requests. Applicants must re-apply annually.

MYLAN EpiPen 2-Pak® Auto-Injector PATIENT ASSISTANCE PROGRAM ("MEPAP")

Patient Assistance Program for EpiPen® (epinephrine injection) Auto-Injector

781 Chestnut Ridge Road / Morgantown, WV 26505 / Phone: 800.395.3376 / Fax: 304.554.4713

Mylan® Seeing is believing

Please print clearly in blue or black ink

(SECTION 1) PATIENT INFORMATION TO BE COMPLETED BY PATIENT OR LEGAL REPRESENTATIVE

First Name:	MI:	Last Name:	Date of Birth:
Mailing Address:			**Apt #:**
City:		**State:**	**Zip Code:**
Social Security Number:		**Gender Male/Female:**	**Preferred Daytime Telephone:**
			( )

(SECTION 2) PATIENT ELIGIBILITY INFORMATION

ATTACH PROOF OF ANNUAL HOUSEHOLD INCOME & LACK OF INSURANCE VERIFICATION (REQUIRED)

GROSS ANNUAL HOUSEHOLD INCOME (Including all Income, Wages, Social Security, Pension, Disability, Unemployment Benefits, Financial Assistance, etc)

Does the patient meet the income requirements of 200% of the current Federal Poverty Guidelines? Yes ❒ No ❒

If "No", the patient is not eligible.

Number of people in household: _____ **$**_____ **Monthly** **$**_____ **Annual**

LACK OF PRESCRIPTION DRUG COVERAGE (Approved documents include: Termination letter, Denial Letter, or Written Statement from Physician)

Is the patient currently enrolled in a Medicare Part D Prescription Drug Plan? Yes ❒ No ❒

Does the patient have any public or private prescription insurance coverage, including Medicaid, TriCare, or a qualified exchange plan offered on a healthcare exchange? Yes ❒ No ❒

Is the patient a U.S. Citizen or legal resident? Yes ❒ No ❒

(SECTION 3) PATIENT AUTHORIZATION FOR INFORMATION USE AND DISCLOSURE

I request and authorize my healthcare professionals and health insurers to disclose to Mylan Specialty and its affiliated companies (collectively, "Mylan") my "Protected Health Information" ("PHI"), as this term is defined under the Health Insurance Portability and Accountability Act of 1996 and its various implementing regulations, as amended ("HIPAA"), so that Mylan may use the information to determine my eligibility for insurance coverage for the Mylan EpiPen 2-Pak® Auto-Injector and to administer my participation in the Mylan EpiPen 2-Pak® Auto-Injector Patient Assistance Program ("MEPAP"). I understand that once disclosed pursuant to this Authorization, my PHI may no longer be protected by federal law and could be re-disclosed to others, but I also understand that Mylan intends to safeguard my PHI and to use and disclose it only for the purposes described herein. I understand that I do not need to sign this Authorization in order to receive healthcare treatment or insurance benefits, and that I may cancel this Authorization at any time by sending a written notice of cancellation by mail to MEPAP Opt-Out Administrator, 781 Chestnut Ridge Road, Morgantown, WV 26505, or by fax to 1-304-554-4713. If I do not cancel it, this Authorization will remain in effect for one year from the date of my signature below. I understand that I have a right to receive a copy of this Authorization when it is signed.

_____	_____	_____
[Name of Patient]	[Signature]	[Date]
_____	_____	_____
[Name of legal representative]	[Signature]	[Date]

If signed by Representative, describe the nature of relationship with patient:

_____

(SECTION 4) PATIENT CERTIFICATION

I certify that the information detailed on this form is indeed complete and accurate. I attest that I have no prescription insurance coverage including under Medicaid, Medicare, TriCare, any healthcare exchange program, or any other public or private program, I have insufficient financial resources to afford the prescribed medication, and I meet the MEPAP income eligibility criteria. Additionally, I agree that at any time during my enrollment, the MEPAP may request additional documentation to authenticate the statements made on my application. I understand and acknowledge that MEPAP assistance may be temporary and that this program may be changed or discontinued at any time without notice.

_____	_____	_____
[Name of Patient]	[Signature]	[Date]
_____	_____	_____
[Name of legal representative]	[Signature]	[Date]

If signed by Representative, describe the nature of relationship with patient:

_____

(SECTION 5) PHYSICIAN INFORMATION

TO BE COMPLETED BY THE PRESCRIBING PRACTITIONER

First Name:	Last Name:	Professional Designation:
State License #:		
Facility Name:		
Shipping Address:		
City:	**State:**	**Zip Code:**
Contact Name:	**Telephone Number:**	**Fax Number:**
	( )	( )

(SECTION 6) PRESCRIPTION INFORMATION AND PHYSICIAN CERTIFICATION

PLEASE ATTACH A COPY OF THE PATIENT'S PRESCRIPTION

EpiPen 2-Pak® Auto-Injector	**0.3 mg/0.3 mL**	❒
EpiPen Jr 2-Pak® Auto-Injector	**0.15 mg/0.3 mL**	❒

I certify that all information I have provided about this patient is complete and accurate, and I understand that the MEPAP and/or its agents are relying on this information to determine patient eligibility. To the best of my knowledge, the patient has no prescription insurance coverage including under Medicaid, Medicare, TriCare, any healthcare exchange programs, or any other public or private program, and the patient has insufficient financial resources and meets the MEPAP income eligibility criteria . I acknowledge and agree not to submit an insurance claim or other claim for payment to any third-party payor (private or government) for the free product provided by the MEPAP. I understand that MEPAP reserves the right to modify or terminate this program at any time. My signature certifies that the medication received from MEPAP will not be resold or offered for sale, trade or barter, and will not be returned for credit. I further certify that no reimbursement of the cost of product has been/will be accepted by me for any treatments where product has been/will be provided free-of-charge by MEPAP, including any product that has already been administered to the patient and for which replacement product will be provided to me. I understand MEPAP reserves the right to recall or discontinue product at any time without notice.

Physician Signature: _____ **Date:** _____

(SECTION 7) FINAL CHECKLIST

Before mailing this application, please take a quick moment to make sure:

- ❒ **Patient or legal representative has completed and signed the application (Sections 1-4)**
- ❒ **Physician has completed and signed the Physician Information and Prescription Information and Physician Certification sections (Sections 5&6)**
- ❒ **A copy of the patient's prescription has been attached (Section 6)**
- ❒ **Copies verifying current financial status have been attached (Please do not send original documents)**
- ❒ **Copies verifying lack of prescription drug coverage have been attached (Please do not send original documents)**

MYLAN EpiPen 2-Pak® Auto-Injector PATIENT ASSISTANCE PROGRAM

Patient Assistance Program for EpiPen® (epinephrine injection) Auto-Injector

781 Chestnut Ridge Road / Morgantown, WV 26505 / Phone: 800.395.3376 / Fax: 304.554.4713

Mylan® Seeing is believing

The Mylan EpiPen 2-Pak® Auto-Injector Patient Assistance Program ("MEPAP") was established to provide free medication to qualified patients. This form is to be used for patients already enrolled in the program and who need a replenishment supply of medication. Additional information related to the program can be obtained by calling 1.800.395.3376 between 8:00 AM and 5:00 PM Eastern Time, Monday through Friday.

REPLENISHMENT AUTHORIZATION FORM
PATIENT INFORMATION TO BE COMPLETED BY PATIENT OR LEGAL REPRESENTATIVE

First Name:	MI:	Last Name:	Date of Birth:
Mailing Address:			**Apt #:**
City:		**State:**	**Zip Code:**
Social Security Number:		**Gender: Male / Female:**	**Telephone Number:** ( )

HEALTHCARE PROFESSIONAL INFORMATION; TO BE COMPLETED BY THE PRESCRIBING PRACTITIONER

First Name:	Last Name:	Professional Designation:
State License #:		
Facility Name:		
Shipping Address (Drugs cannot be shipped to the patient or P.O. Box)		
City:	**State:**	**Zip Code:**
Contact Name:	**Telephone Number:** ( )	**Fax Number:** ( )
Mailing Address: (If different from shipping address)		
City:	**State:**	**Zip Code:**

PRESCRIPTION INFORMATION AND PHYSICIAN CERTIFICATION

PLEASE ATTACH A COPY OF THE PATIENT'S PRESCRIPTION

EpiPen 2-Pak® Auto-Injector	**0.3 mg/0.3 mL**	❒
EpiPen Jr 2-Pak® Auto-Injector	**0.15 mg/0.3 mL**	❒

I certify that all information I have provided about this patient is complete and accurate, and I understand that the MEPAP and/or its agents are relying on this information to determine patient eligibility. To the best of my knowledge, the patient has no prescription insurance coverage, including under Medicaid, Medicare, Tricare, any healthcare exchange programs, or any other public or private program, and the patient has insufficient financial resources and meets the MEPAP income eligibility criteria. I acknowledge and agree not to submit an insurance claim or other claim for payment to any third-party payor (private or government) for the free product provided by MEPAP. I understand that MEPAP reserves the right to modify or terminate this program at any time. My signature certifies that the medication received from MEPAP will not be resold or offered for sale, trade or barter and will not be returned for credit. I further certify that no reimbursement of the cost of product has been/will be accepted by me for any treatments where product has been/will be provided free-of-charge by MEPAP, including any product that has already been administered to the patient and for which replacement product will be provided to me. I understand MEPAP reserves the right to recall or discontinue product at any time without notice. I certify that the patient requires additional free product for his/her personal use.

Physician Signature: _____ **Date:** _____

FINAL CHECKLIST

Before faxing this application, please take a quick moment to make sure:

- ❒ **Patient or legal representative has completed the Patient Information section**
- ❒ **Physician has completed and signed the Healthcare Professional Information & Prescription Information and Physician Certification sections**
- ❒ **A copy of the patient's prescription has been attached**

Fax the completed form to 1.304.554.4713 for approval

REMEMBER: An incomplete Replenishment Authorization form will delay processing. Call 1.800.395.3376 with questions about the form.

EPI-2015-0684