Mylan
Seeing is believing

Mylan Miacalcin Injection Patient Assistance Program

Mylan Patient Assistance Program
PO Box 219, Gloucester, MA 01930
Phone: 888.238.5694 Fax: 888.246.6527

Policies and Procedures

Thank you for your interest in the Mylan Miacalcin Injection Patient Assistance Program ("MMPAP").
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 a seal, etc.

Physician

- The physician must complete, sign and submit the MMPAP Application acknowledging that the patient is in need of assistance.
- The product will be shipped from the MMPAP 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 Miacalcin Injection Patient Assistance Program at 888.238.5694 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 the MMPAP.

Completed forms and required documentation for the Mylan Miacalcin Injection Patient Assistance Program should be mailed or faxed to:

Mylan Miacalcin Injection Patient Assistance Program
PO Box 219, Gloucester, MA 01930
Fax: 888.246.6527

Additional information about the Mylan Miacalcin Injection Patient Assistance Program is available by calling 888.238.5694
Mylan reserves the right to discontinue or modify this program at any time.

A prescription for a one month supply with up to a maximum of 2 refills is required.
If the applicant is approved for the program, a one month supply of requested medication will be shipped to the physician's office to be dispensed to the patient free-of-charge.

Approximately 80 days after the initial approval date, a replenishment authorization form must be submitted by the prescribing physician to continue to receive the medication through the MMPAP. Replenishment authorization forms can by obtained by calling 888.238.5694.
Applicants must reapply annually for verification of eligibility.

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Mylan Miacalcin Injection Patient Assistance Program ("MMPAP")

PO Box 219 Gloucester, MA 01931 Phone: 888.238.5634 / Fax: 888.246.6527

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:		City:	State:	Zip:
Social Security Number or Green Card Number (if applicable):		Gender: Male ☐ Female ☐	Preferred Daytime Telephone: ( )	
Email:		Fax: ( )		

By providing your email, phone, and/or fax, you are giving us and people contacting you on our behalf your permission to contact you in this way.

(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 health plan offered on a health care 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 health care providers and health insurers to disclose to Mylan Institutional Inc. and its affiliated companies and its contractors (collectively, "Mylan") my personal health information ("PHI") so that Mylan may use the information to determine my eligibility for insurance coverage for Mylan Miacalcin and to administer my participation in the Mylan Miacalcin Injection Patient Assistance Program ("MMPAP"). 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 health care treatment or insurance benefits, and that I may cancel this Authorization at any time by sending a written notice of cancellation by mail to MMPAP Opt-Out Administrator, P.O. Box 219, Gloucester, MA 01930, or by fax to 1-888-246-6527. 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 health care exchange program, or any other public or private program, I have insufficient financial resources to afford the prescribed medication, and I meet the MMPAP income eligibility criteria. Additionally, I agree that at any time during my enrollment, the MMPAP may request additional documentation to authenticate the statements made on my application. I understand and acknowledge that MMPAP 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 # and Expiration Date:	**Facility Name:**		
Facility Address:	**City:**	**State:**	**Zip:**
Contact Name:	**Telephone Number:** ( )	**Fax Number:** ( )	
Email:	**By providing your email, phone, and/or fax, you are giving us and people contacting you on our behalf your permission to contact you in this way.**		
Shipping Address: (If different from facility address)	**City:**	**State:**	**Zip:**

Please Note: Medication cannot be shipped to the patient or P.O. Box

Is refrigeration available to keep the product at 2° C-8°C (36°F - 46°F) ? **Yes ☐ No ☐**

List any days of the week you could NOT receive this refrigerated medicine ______________________

(SECTION 6) PRESCRIPTION INFORMATION AND PHYSICIAN CERTIFICATION

PLEASE ATTACH A COPY OF THE PATIENT'S PRESCRIPTION

Miacalcin **200IU/mL 2mL MDV 1PK** ☐ **Quantity per day:**

I certify that all information I have provided about this patient is complete and accurate, and I understand that the MMPAP 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 health care exchange programs, or any other public or private program, and the patient has insufficient financial resources and meets the MMPAP 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 MMPAP. I understand that MMPAP reserves the right to modify or terminate this program at any time. My signature certifies that the medication received from MMPAP 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 MMPAP, including any product that has already been administered to the patient and for which replacement product will be provided to me. I understand MMPAP reserves the right to recall or discontinue product at any time without notice.

Physician Signature: ______________________________________ **Date:** ____________________

(SECTION 7) FINAL CHECKLIST

Before sending 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 verifiying lack of prescription drug coverage have been attached (Please do not send original documents)**