ARBOR PHARMACEUTICALS PATIENT ASSISTANCE PROGRAM

951 Clint Moore Road - Suite A, Boca Raton, FL 33487 Telephone: (888) 417-7153/ Fax: (407) 641-9566

PATIENT ASSISTANCE PROGRAM

Dear Applicant,

Thank you for your interest in the Arbor Pharmaceuticals, LLC. Patient Assistance Program (PAP). Enclosed you will find the requested application. It is important that you complete all requested information and sign where indicated. Incomplete or incorrect applications will delay the application process.

PATIENT REQUIREMENTS:

- ✓ Complete all fields in Sections 1.1 & 1.2 on Page 1 of the Application
- ✓ Complete Certification Sections 3.1 & 3.2 *(if applicable)* on Page 2 of the Application
- ✓ **Attach** a copy of the ANNUAL household income (Federal tax return (1040), social security income (SSA 1099), pensions, interest, retirement, child support, etc.). See income requirements on the next page.
- ✓ **Attach** a photocopy of your LIS Denial Letter (for Medicare Part D plan applicants only)
  If you are a Medicare Part D enrollee you must have applied for and been denied the Low Income Subsidy (LIS) from the Social Security Administration. In order to apply for LIS, please contact the SSA at (800) 772-1213 or go to www.socialsecurity.gov/prescriptionhelp/.
- ✓ **Attach** a photocopy of your Medicaid Denial *(if applicable)*
  If you have applied for Medicaid in the past and been denied, please attach a copy of Medicaid denial.

LICENSED PRACTITIONER REQUIREMENTS:

- ✓ Complete all fields in Sections 2.1 & 2.2 on Page 1 of the Application
- ✓ Complete Certification Section 4.1 on Page 2 of the Application
- ✓ **Attach** a photocopy of the prescription written for medication listed in section 2.2.
  Note: If the preprinted office address on the prescription does not match the delivery/mailing address provided in Section 2.1 on the Arbor Pharmaceuticals, LLC. PAP Application form, then the licensed practitioner must attach a copy of their letterhead or a business card to verify the delivery/mailing address provided in Section 2.1.

MAIL COMPLETED APPLICATION TO:
Arbor Pharmaceuticals, LLC.
Patient Assistance Program
957 Clint Moore Road - Suite A
Boca Raton, FL 33487

OR FAX TO:
(407) 641-9566

APPLICATION PROCESSING:

Please allow 4 weeks for application processing and delivery of medication to the licensed practitioner named on the application form. If the applicant is approved a 3-month supply of the drug requested will be shipped to the licensed practitioner's office for dispensing. Upon approval, the applicant and licensed practitioner will be notified by email and mail. If the applicant is denied, the licensed practitioner and the applicant will be notified by mail. Incomplete applications will be returned to the applicant or licensed practitioner with instructions for completion. If a qualifying applicant requires a subsequent shipment of the medication, the applicant must re-apply for the program as directed by customer service.

If you have questions or need further assistance, please call 1-888-417-7153 between 9:00 AM and 5:00 PM EST, Monday through Friday.

Sincerely,
Arbor Pharmaceuticals, LLC.
Patient Assistance Program[i]

ARBOR PHARMACEUTICALS PATIENT ASSISTANCE PROGRAM
951 Clint Moore Road - Suite A, Boca Raton, FL 33487 Telephone: (888) 417-7153/ Fax: (407) 641-9566

ELIGIBILITY REQUIREMENTS

Eligibility is based on the following requirements:

- You must not be covered by any private, public, or Medicare Part D health insurance and prescription coverage programs.
- You must be a citizen of the United States or its Territories.
- You must be an outpatient currently under the care of a physician.
- Your income must be less than or equal to 200% of the Federal Poverty Guideline (300% for BiDil) for the size of your household (see chart below).

Family Size	BiDil			All Other Products		
Persons in Family or Household	48 Contiguous States and D.C.	Alaska	Hawaii	48 Contiguous States and D.C.	Alaska	Hawaii
1	$34,470	$43,050	$39,690	$22,980	$28,700	$26,460
2	$46,530	$58,140	$53,550	$31,020	$38,760	$35,700
3	$58,590	$73,230	$67,410	$39,060	$48,820	$44,940
4	$70,650	$88,320	$81,270	$47,100	$58,880	$54,180
5	$82,710	$103,410	$95,130	$55,140	$68,940	$63,420
6	$94,770	$118,500	$108,990	$63,180	$79,000	$72,660
7	$106,830	$133,590	$122,850	$71,220	$89,060	$81,900
8	$118,890	$148,680	$136,710	$79,260	$99,120	$91,140
For each additional person, add	$ 12,060	$ 15,090	$ 13,860	$ 8,040	$10,060	$ 9,240

Federal Poverty Level Guidelines 2013

ARBOR PHARMACEUTICALS PATIENT ASSISTANCE PROGRAM

951 Clint Moore Road - Suite A. Boca Raton, FL 33487 Telephone: (888) 417-7153/ Fax: (407) 641-9566

APPLICATION

SECTION 1.1: PATIENT INFORMATION

First Name (legal)	MI	Last Name	Gender: (circle one) M F
Phone Number	Social Security Number		Date of Birth
Mailing Address			Apt Number
City	State		Zip Code
Marital Status	Email Address		

Gross Monthly HOUSEHOLD Income:_____ Number of People in Household (include yourself):_____

Have you attached a photocopy of your annual household income (Federal tax return (1040), social security income (SSA 1099), pensions, interest, retirement, child support, etc.)? ☐ Yes ☐ No

Do you have prescription coverage/reimbursement at any time during the year? ☐ Yes ☐ No

If yes, please provide your carrier's name & benefits received for the requested medication:_____

SECTION 1.2: MEDICARE/MEDICAID INFORMATION

Are you enrolled in Medicare? ☐ Yes ☐ No Are you enrolled in Medicaid? ☐ Yes ☐ No

Medicare ID#:_____ Are you enrolled in Medicare Part D plan? ☐ Yes ☐ No

*Medicare Part D enrollees: you must have applied for and been denied the Low Income Subsidy (LIS) from the Social Security Administration before submitting this application. In order to apply for LIS, you may contact the Social Security Administration at (800) 772-1213, or visit www.socialsecurity.gov/prescriptionhelp/.

Please attach a photocopy of your LIS denial letter to this application.

Have you attached a copy of your Medicare Part D LIS Denial Letter? ☐ Yes ☐ No

SECTION 2.1: LICENSED PRACTITIONER INFORMATION (To be completed by the patient's licensed practitioner)

First Name (legal)	MI		Professional Designation
State License Number		DEA Number	
Mailing Address	City	State	Zip Code
Delivery Address	City	State	Zip Code
Office Contact Name	Phone Number		Ext.
Office Contact Email Address			

SECTION 2.2: PRESCRIPTION INFORMATION (To be completed by the patient's licensed practitioner)

Medication:_____ Dosage:_____

* Attach a copy of the prescription to this application *

BOTH PATIENT AND LICENSED PRACTITIONER MUST SIGN AND DATE THE CERTIFICATIONS ON PAGE 2 OF THIS APPLICATION

ARBOR PHARMACEUTICALS PATIENT ASSISTANCE PROGRAM
951 Clint Moore Road - Suite A, Boca Raton, FL 33487 Telephone: (888) 417-7153/ Fax: (407) 641-9566

CERTIFICATIONS

SECTION 3.1: PATIENT CERTIFICATION

I certify that I do not have the ability to pay for the medication requested by my licensed practitioner in section 2.2 of this application and all information provided in section 1.1 and 1.2 is correct. I understand that Arbor Pharmaceuticals, LLC. Patient Assistance Program is entitled to request additional verification of any such information at any time, which I agree to provide. I consent that Arbor may contact me for verification of my application status and receipt of the indicated medications. I understand that if approved, I am not eligible to seek reimbursement for any medication requested in section 2.2 of this application from any government program or third party insurer. I understand eligibility under the Arbor Pharmaceuticals, LLC. PAP is subject to Arbor's discretion and that Arbor reserves the right to modify or terminate the PAP at any time. I authorize my physician to provide Protected Health Information ("PHI") (as such term is defined in the Health Insurance Portability and Accountability Act and regulations there under, "HIPAA", as well as other state or federally protected personal information), to Arbor or third parties engaged, as required to assist Arbor in administering the PAP. I authorize Arbor to disclose my PHI to Centers for Medicare and Medicaid Services ("CMS") for the purpose of verifying my Medicare Part D enrollment status and disclosing my enrollment in Arbor Pharmaceuticals, LLC. PAP with my Medicare Part D plan. I understand that my PHI will consist of my name, address, social security number, income, prescription coverage, prescription for medication, financial documents and insurance records and will be used for purposes of determining my eligibility to participate in the Arbor PAP and to ship appropriate medication(s) as prescribed by my licensed practitioner. I further understand that if my PHI is incomplete or completed PHI does not allow me to participate in Arbor's PAP that I may be notified of such by Arbor. I understand that upon the furnishing of my PHI to Arbor, my PHI may not be subject to all of the protections and safeguards provided by HIPAA or other federal and state privacy laws. This authorization will extend for as long as I participate in the PAP and will thereafter expire. I may revoke this authorization at any time by providing written notice to Arbor at the address set forth above. My revocation will become effective on the date my written notice is received and processed at Arbor Pharmaceuticals, LLC. PAP.

Patient or Legal Guardian's ORIGINAL Signature: **Date:**

SECTION 3.2: MEDICARE PART D ENROLLEE CERTIFICATION *(if applicable)*

I understand that if I am approved for Arbor Pharmaceuticals, LLC. PAP, I will receive a three month supply of medication and that I must re-apply to Arbor Pharmaceuticals, LLC. PAP each time I need medication. I understand that if my application continues to meet the guidelines of Arbor Pharmaceuticals, LLC. PAP, I will continue to be approved to receive subsequent three month supplies of medication. I agree that I will not seek the requested Arbor medication from my Medicare Part D prescription plan while receiving the medication from Arbor PAP. I understand that I am not eligible to seek reimbursement for any medication dispensed by Arbor from any government program or third party insurer and will not apply any Arbor Pharmaceuticals, LLC. PAP medication towards True-Out-Of-Pocket ("TrOOP") costs.

Patient or Legal Guardian's ORIGINAL Signature: **Date:**

SECTION 4.1: LICENSED PRACTITIONER CERTIFICATION

My signature certifies that I am a licensed practitioner eligible under state law, my collaborative agreement and formulary, if applicable, to prescribe, receive and dispense the requested medication(s) listed on this application, provided by Arbor Pharmaceuticals, LLC. I further certify all information provided in section 2.1 & 2.2 is correct and agree to submit appropriate verification of such information upon Arbor's reasonable request. I agree that medication(s) provided to me by Arbor pursuant to prescriptions provided by me for the applicant named in 1.1 will be provided by me to such eligible applicant for his or her own use without charge. I will not otherwise use any of such medications or prescribe, provide or dispense all or any portion thereof for the use of any other person. I consent that Arbor may contact the applicant named in section 1.1 for verification of applicant status and receipt of the indicated medication(s). I further consent that Arbor may perform an on-site audit of PAP records related to the applicant named in 1.1 of this application. I understand that I am not eligible to seek reimbursement for any medication dispensed by Arbor Pharmaceuticals, LLC. PAP from any government program or third party insurer and will not apply any Arbor PAP medication towards the applicants TrOOP. I further understand that I cannot seek payment for an office visit from the applicant or third party insurer when Arbor PAP medication is provided to the applicant. I also understand that eligibility under the PAP is subject to Arbor Pharmaceuticals, LLC.'s discretion and that Arbor Pharmaceuticals, LLC. reserves the right to modify or terminate the PAP at any time.

Physicians ORIGINAL Signature: **Date:**