PERNIX THERAPEUTICS

Patient Assistance Program

How to Apply

Program Eligibility

Pernix Therapeutics offers a patient assistance program providing Pernix Therapeutics brand name medications to individuals who meet eligibility requirements. Eligibility is based on your annual household income and prescription insurance status. To see if you are eligible, complete and return this form. If you qualify, you will automatically be mailed your first 90-day supply. You will then be eligible to receive free brand name medicine(s) for up to one year by calling to refill your prescription every month. You must re-enroll each year to remain in the program.

You should apply for this patient assistance program if:

- ☐ You have a valid prescription for a Pernix Therapeutics brand name medication listed below. Please make sure the prescription indicates that the medication to be filled is for the brand name medication, not the chemical generic medication.
- ☐ You **do not** have prescription insurance coverage
- ☐ Your total household income meets the guidelines below

2015 Income Guidelines*

Household size including yourself	1	2	3	4	5	6	7	8
Annual household income limit (Lower 48 states)*	$29,425	$39,825	$50,225	$60,625	$71,025	$81,425	$91,825	$102,225
Annual household income limit (Alaska)**	$36,800	$49,800	$62,800	$75,800	$88,800	$101,800	$114,800	$127,800
Annual household income limit (Hawaii)***	$33,875	$45,825	$57,775	$69,725	$81,675	$93,625	$105,575	$117,525

* For family units of more than 8 members, add $4,160 for each additional member.
** For family units of more than 8 members, add $5,200 for each additional member.
*** For family units of more than 8 members, add $4,780 for each additional member.

Pernix Therapeutics Medication

- ☐ Silenor® (doxepin) tablets
- ☐ Treximet® (sumatriptan / naproxen sodium)

Application Checklist

- ☐ Complete the Enrollment Form and be sure to sign on Page 2.
- ☐ Provide your name, address, city, state and zip.
- ☐ Number of people, including the patient, contributing to or dependent on the household income.
- ☐ Provide your household's **gross annual income** including all income received by all household members. Gross annual income is your total household's income before deductions and expenses.

  Required Documentation:
  If you or any member of your household filed or was listed as a dependent on a federal income tax form, please provide a copy of page one of the most recently filed tax return(s). Acceptable tax forms are 1040, 1040A or 1040EZ.

  If no one in your household filed a federal income tax form for the most recent tax year or if the available federal income tax form does not represent your current household income, please attach proof of income from all sources for the most recent 30-day period for all household members including paycheck stubs, unemployment stubs, Social Security statements, pension statements, etc.
- ☐ Attach your original prescription for an Pernix Therapeutics brand name medicine. Please make sure the prescription indicates that the medication to be filled is for the brand name medication not the chemical generic medication.

Mail or fax your completed application, supporting documents and prescription to:**
Pernix Therapeutics Patient Assistance Program, PO Box 32444, Charlotte, NC 28232 or Fax 919-882-1659**
For additional information call 1-800-340-3042 Mon-Fri between 9 a.m. and 5 p.m. ET
Visit pap.pernixtx.com

*Faxed prescriptions will be accepted only when faxed directly from a prescriber's office to the program. The fax must include a cover page with the prescriber's contact information, medical provider address, DEA number and patient name. Faxed prescriptions without this information will not be accepted and will be discarded.

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Patient Assistance Program
Enrollment Form

A. About you

First name: MI: Last name:

Address (No PO Boxes):

City: State: ZIP: –

Daytime phone: ( ) – Gender: Male Female

Date of birth (mm-dd-yyyy): – – DL #:

Email:

Number of people, *including yourself*, contributing to or dependent on the household income: _____

Gross annual income for entire household (rounded to the nearest dollar): $ _____

B. Your health insurance

Do you have any prescription drug insurance coverage? Yes No

C. Your health and medicine information

List any known allergies:
None

List any known health conditions:
None

List all medicines (prescription and non prescription) that you take:
None

Before mailing your application

- ☐ Be sure your application is complete. An incomplete application will delay processing.
- ☐ Sign the Consent and Release of Information on Page 2.
- ☐ Attach your income documentation.
- ☐ Attach your signed, original prescription (no copies) for an Pernix Therapeutics brand name medication. Please make sure the prescription indicates that the medication to be filled is for the brand name medication not the chemical generic medication.
- ☐ Print your name and date of birth on all attachments. Keep a copy of this form for your records.

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Be sure to sign Page 2

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D. Your consent and release of information

By my signature I authorize Pernix Therapeutics, as well as any other companies Pernix Therapeutics uses to administer the patient assistance program (the "Program"), to do the following:

1. Use information contained on my application for the purpose of helping me receive certain prescription medications pursuant to my participation in the Program;
2. Administer the Program;
3. Receive and keep records for all prescriptions medications I receive under the Program;
4. Contact my healthcare providers about my application for the Program;
5. Disclose information contained in my application to my healthcare providers to provide me with prescription medications;
6. Contact and request information from my insurer, the Centers for Medicare and Medicaid Services, social workers or patient advocacy organizations, or my healthcare providers about the prescribed medication I receive or will receive under the Program, about my medical condition or about my eligibility for health insurance coverage or other funds, and disclose to them information contained in my Program application or information about my prescribed medications and medical condition that has been provided by my healthcare providers. This information will be used only to determine my eligibility for the Program and to administer the Program; and
7. Disclose any information obtained from my application and the sources listed about to third parties if required by law.

By signing below, I also authorize my healthcare providers to release information about my prescribed medications and medical condition that is requested by Pernix Therapeutics or any company that Pernix Therapeutics uses to administer the Program.

I agree to provide to Pernix Therapeutics with any requested documentation to verify that the information provided is correct, including bank statements, Federal Tax Returns, verification of non-filing for Federal Tax, W-2 forms, denial from insurance companies or state or government programs, etc.

I understand that this authorization will remain in effect for as long as I participate in the Program and for a period of three (3) years after my participation in the Program ends. I understand that if my participation in the Program lapses or if I re-enroll in the Program, I may be asked to sign another authorization.

I understand that my healthcare providers will not condition my medical treatment on my agreement to sign this authorization.

I understand that I have the right to revoke this authorization at any time by providing a signed written letter to Pernix Therapeutics stating the same. Such revocation will end my eligibility in the Program. Revoking this authorization will prohibit disclosures after the date written revocation is received by Pernix Therapeutics except to the extent that the action has been taken in reliance on my authorization or as required by law. I understand that once information has been disclosed in reliance upon this authorization, the information may no longer be protected by federal privacy laws and may be further disclosed by the recipients of the information.

I understand that Pernix Therapeutics does not charge a fee for participation in the Program and Pernix Therapeutics is not responsible for any copayment or other fee charged by any other party as part of obtaining a prescription or filling a prescription. I understand Pernix Therapeutics reserves the right to cancel or modify the Program, or my participation in the Program at any time. Although medication may be given to me without cost now or at some point in the future, it does not mean that I will be entitled to receive it without cost indefinitely. I understand that the eligibility for enrollment in the Program is subject to Pernix Therapeutics' approval. Pernix Therapeutics reserves the rights to make a separate, independent determination of patient eligibility. I agree to notify Pernix Therapeutics immediately of any changes that might affect my eligibility.

I certify that I am not enrolled in any Medicare plan that includes Part D drug coverage or any other government or private prescription drug plan. I understand that if I enroll in any other prescription drug plan, I may no longer meet the eligibility requirements of this assistance program, even if the benefit program does not cover the full cost of, or places limits on, medications. Furthermore, I certify that the information provided in this application is complete and accurate to the best of my knowledge and agree to notify Pernix Therapeutics of any change in my insurance eligibility, under any other government or private prescription drug plan or change in my financial status. By signing below, I consent to Pernix Therapeutics verifying any information provided on this application and affirm that my answers are accurate to the best of my knowledge.

SIGN

Applicant Signature _____ Date _____ Relationship if other than applicant _____

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4. Contact my healthcare providers about my application for the Program;
5. Disclose information contained in my application to my healthcare providers to provide me with prescription medications;
6. Contact and request information from my insurer, the Centers for Medicare and Medicaid Services, social workers or patient advocacy organizations, or my healthcare providers about the prescribed medication I receive or will receive under the Program, about my medical condition or about my eligibility for health insurance coverage or other funds, and disclose to them information contained in my Program application or information about my prescribed medications and medical condition that has been provided by my healthcare providers. This information will be used only to determine my eligibility for the Program and to administer the Program; and
7. Disclose any information obtained from my application and the sources listed about to third parties if required by law.

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I understand that Pernix Therapeutics does not charge a fee for participation in the Program and Pernix Therapeutics is not responsible for any copayment or other fee charged by any other party as part of obtaining a prescription or filling a prescription. I understand Pernix Therapeutics reserves the right to cancel or modify the Program, or my participation in the Program at any time. Although medication may be given to me without cost now or at some point in the future, it does not mean that I will be entitled to receive it without cost indefinitely. I understand that the eligibility for enrollment in the Program is subject to Pernix Therapeutics's approval. Pernix Therapeutics reserves the rights to make a separate, independent determination of patient eligibility. I agree to notify Pernix Therapeutics immediately of any changes that might affect my eligibility.

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SIGN

Applicant Signature _____ Date _____ Relationship if other than applicant _____

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