Photofrin® Patient Assistance Program

Phone: 855-215-2720 Fax: 855-314-3943

The Photofrin® Patient Assistance Program is designed to assist financially disadvantaged individuals that have no prescription coverage such as Medicaid, Medicare prescription drug coverage, state-sponsored prescription drug assistance, employee, military, retirement or pension program drug coverage.

PATIENT ELIGIBILITY CRITERIA (patient must meet all of the criteria):

- You must be a legal resident of the United States or its Territories.
- You must not have coverage for Photofrin® through any public, private or Medicare Part D prescription coverage program.
- Your annual household income must be at or below 200% of the current Federal Poverty Level.
- This application must be completed in its entirety and signed and dated by both you and your physician (no stamped signatures will be accepted).
- A copy of your most recent Federal tax return must be submitted with the program application form. If you do not file a Federal tax return, you must submit alternate proof of income.

APPLICATION PROCESS:

- Complete the enclosed application in its entirety. **Incomplete applications will be denied**.
- Submit the application by mail or fax to the address or fax number listed at the top of the form.
- Include a copy of your most recent Federal tax return. If you do not file a Federal tax return, you must provide alternate income documentation. Your documentation must support all income values you list on the application form. Acceptable document types include: W-2 forms, pay statements, Social Security, pension, or retirement statements, bank statements, statements of interest, dividends, or other income.
- A Patient Assistance Liaison will evaluate your application using pre-established program guidelines to determine your eligibility.
- You and your physician will be notified by phone, fax, or mail regarding the outcome of your acceptance into the program.

Patient Assistance Program Application

2730 S. Edmonds Lane, Suite 300
Lewisville, TX 75067
Phone: 855.215.2720 Fax: 855.314.3943

Applicant Information

First Name:	M.I.:	Last Name:
Address:		
City:	State:	Zip Code:
Daytime Phone:	DOB:	SSN:
Gender: Male ☐ Female ☐	Single ☐ Married ☐ Widowed ☐ Divorced ☐	US Resident: Yes ☐ No ☐

Financial Information

All Values below should reflect Annual Amounts for Entire Household

Salary / Wages / Unemployment	$	Disability	$
Pension / Retirement	$	Alimony / Child Support	$
Social Security	$	Other	$
Number of people in household dependent on reported income (including self): _____		☐ Attached is a copy of my most recent Federal tax return ☐ I do not file a Federal tax return. Attached are documents to support all income values listed above	

Applicant Declaration and Authorization to Share Health Information

I allow my health care providers, physicians, specialty distribution center, third party service provider (collectively "providers") to use, share and disclose my protected health information (PHI) and financial information. My PHI will be given to Pinnacle Biologics, Inc ("Pinnacle"), its vendor Cardinal Health, Inc., and any other affiliated companies, subcontractors, vendors or partners that help with the management of the Patient Assistance Program (the "Program"). My information will be treated confidentially to the extent required by law; however, I understand:

- The Program may only use my information for the purpose of evaluating my eligibility to the Program so that, if approved, I can receive Photofrin®.
- If my PHI is disclosed federal privacy laws may no longer protect it
- I can cancel or revoke this authorization at any time by writing to the Program address above
- This authorization will expire one (1) year from the date of my signature

Applicant's Certification: My signature certifies that **1**) I have read and understand the above regarding the release of my PHI to the Photofrin® Patient Assistance Program including its use and disclosure purposes; **2**) The information provided in this application is current, complete, and accurate; **3**) I do not have prescription drug coverage of any kind that would cover Photofrin®; **4**) Upon approval, I authorize Pinnacle, its vendor Cardinal Health, inc. and any other affiliated companies, subcontractors, vendors and/or partners that help with the Program to forward my information to a dispensing entity on my behalf; **5)** I understand that, once dispensed, Pinnacle will send the medication to my physician listed below for dispensing to me; **6**) I shall not seek reimbursement from any source, including any government program or third party insurer for any medication dispensed through this Program; **7)** All information provided as part of this application is for the express and sole purpose of qualifying for eligibility to receive Photofrin® at no cost through Program; **8)** I understand that Program eligibility is subject to Pinnacle's discretion and Pinnacle reserves the right to modify or terminate the Program at any time; **9)** I hereby release and forever discharge Pinnacle and its vendor Cardinal Health, Inc. from any and all liability related to the Program.

Patient Signature _____ **Date** _____

Physician Information

Physician Name:	Physician License #:	
Practice Name:		
Address:		
City:	State:	Zip Code:
Office Contact Name:	Phone #:	Fax #:

Physician Certification : My signature certifies **1)** I am duly licensed and authorized under applicable law to prescribe, receive and dispense the medication requested in this application to the patient listed above (the "Patient"); **2)** The information provided above is complete and accurate; **3**) I understand that, if the Patient is approved for the Program, the requested medication shall be sent to my office for dispensing to the Patient; **4**) I have prescribed the requested medication for the Patient and the medication shall be used for the sole purpose of treating the Patient for an indication that is consistent with the FDA Approved label use of PHOTOFRIN®; **5**) The medication will not be offered for sale, trade or barter; **6**) I shall not seek reimbursement from any source for the requested medication or a related office visit, including the Patient or any private or public health care program or third party payor; **7)** I consent to an on-site audit of any information related to the Program; **8)** I understand that Program eligibility is subject to Pinnacle's discretion and Pinnacle reserves the right to modify or terminate the Program at any time.

Physician Signature _____ **Date** _____
(original signature required)