CHIESI

CARE DIRECT™

Patient Assistance Program

Call for assistance:
1-888-865-1222

Patient Assistance Program Application

How to apply:

- Please complete the application in its entirety.
- Please sign the ***Patient Certification and Authorization to Disclose Information*** section.
- Attach a copy of your household's Federal Tax Return; if you do not file taxes, please include other proof of yearly household income such as pay stubs, a bank statement of deposit, social security or disability statement, unemployment award letter, etc.
- If you have prescription drug insurance, please be sure to include a photocopy of the front and back of your prescription insurance card.
- Mail or fax the application, a photocopy of your household's Federal Tax Return (or other proof of income) and the photocopy of your prescription insurance card, if applicable, to the address or fax number above.

What's required to be eligible for Chiesi CareDirect Patient Assistance Program:

- You must be a legal U.S. resident.
- You cannot have any prescription coverage for the requested Chiesi CareDirect medication/s through third-party insurers such as Medicaid, Medicare Part D, private insurance or Health Management Organizations.
- If you have prescription coverage, please provide a photocopy of the front and back of your prescription insurance card.
- You cannot have or qualify for federal, state or private insurance reimbursement for the Chiesi CareDirect medication/s being requested.
- The amount of your contribution towards the cost of your requested Chiesi CareDirect medication/s, if any, will depend upon your income and household size.

Fax or Mail your application and supporting documents to:
Fax: 1-866-410-6241
Chiesi CareDirect
Patient Assistance Program
PO Box 30317
Bethesda, MD 20824-0317

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CAREDIRECT™

Patient Assistance Program

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PO Box 30317
Bethesda, MD 20824-0317

Product Selection

I am requesting financial assistance for the following product(s):

❑ PERTZYE® (pancrelipase) ❑ BETHKIS® (Tobramycin Inhalation Solution)

Patient Information *The patient or his/her legal representative must complete this section*

Today's Date:

First Name: M.I.: Last Name:

Social Security #: Date of Birth:

If you do not have a SS #, please provide another form of ID (i.e. Green Card or Work Visa number)

Address: Apartment/Suite #:

City State: ZIP Code:

Home Phone: Cell Phone:

How many people live in your household? 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8+❑

Annual Household Income: (*Including SSI, pension income, etc.)* $

Do you have private Rx insurance? Yes ❑ No ❑ Are you a legal resident of the U.S.? Yes ❑ No ❑

Do you have government Rx insurance? Yes ❑ No ❑ *Such as: Medicare D, Medicaid, Veteran's Administration, State or other government sponsored program*

Insurance Company Name:

Member ID# : Group # :

Patient Disclaimer and Signature

I attest that the above information is complete and accurate. I attest that I have no or insufficient prescription insurance coverage for the indicated medication, including Medicaid, Medicare or any other public or private program and I have insufficient financial resources to pay for the prescribed therapy.

I understand and agree that PAP medication received will not count toward my true-out-of-pocket costs (TROOP) as defined under the Medicare Modernization Act. I understand that the PAP medication will be dispensed to me by my physician and is provided at no charge to me or any other party; therefore, I agree that I will not submit any claim for the PAP medication to any third party, including my Medicare Part D Plan. I further agree that I will seek no reimbursement for any drug(s) obtained under this program. By my signature, I authorize the release of the information about me and my medical condition to Chiesi CareDirect and/or their agents. I authorize Chiesi CareDirect and/or their agents to use and disclose such information for the assessment of my eligibility for and enrollment and administration of Chiesi CareDirect, which may include contacting my insurer, public funding programs, social workers, advocacy organizations, healthcare providers, or other persons or entities Chiesi Cares may deem appropriate to release all medical records or requested information bearing on my eligibility to and benefits under the program. Additionally, I agree that at any time during my enrollment, Chiesi CareDirect may request additional documentation to authenticate the statements made on my application. Chiesi CareDirect and/or their agents agree to not disclose any information to any third party except those required for program administration as authorized by me or as required by law. I understand and acknowledge that this assistance is temporary and that this program may be changed or discontinued at any time without notice. The information above will append the incomplete information provided on my original enrollment application.

Patient or Legal Guardian's Original Signature Required: Date: