CHIESI
CARE DIRECT
Patient Assistance Program

Call for assistance:
1-888-865-1222

Patient Assistance Program Application

How to apply:

Applicant

- 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.

Licensed Healthcare Provider ("HCP")

- An HCP is required to complete the Healthcare Provider Section. In addition, the same HCP must attach a valid prescription for the requested Chiesi CareDirect medication or complete the prescription on the application, if permitted by law. If the preprinted office address on the prescription does not match the delivery/mailing address on the application form, the HCP must also attach letterhead, coversheet or a business card to verify the delivery/mailing address on the application form in the Healthcare Provider section.
    - Please sign and date the certification section. Signature and date are valid for one (1) year.

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 any other state or federally subsidized pharmacy benefit program
- You must be uninsured or underinsured
    - Uninsured means that you do not have any insurance or that you only have medical insurance with no prescription benefits
    - Underinsured means that your private insurer does not provide coverage for the Chiesi CareDirect medications requested after receiving proof of medical necessity from your healthcare provider or that you have a co-insurance responsibility that is 100% of the medication cost after your deductible is satisfied
- You cannot have or qualify for federal, state or private insurance reimbursement for the Chiesi CareDirect medication/s being requested.

Fax, mail or email your application and supporting documents to:
Fax: 1-866-410-6241
Chiesi CareDirect
Patient Assistance Program
PO Box 30317
Bethesda, MD 20824-0317
chiesicaredirect@caremetx.com

CHIESI
CAREDIRECT®
Patient Assistance Program

Phone: 1-888-865-1222
Fax: 1-866-410-6241
PO Box 30317
Bethesda, MD 20824-0317

Product Selection

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

☐ PERTZYE® (pancrelipase) ☐ BRONCHITOL® (mannitol) inhalation powder

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:

Email Address:

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

☐ By checking this box, and by signing the section below. I attest that I will immediately notify Chiesi CareDirect upon any changes to the information provided in this application, including but not limited to, insurance eligibility, coverage details, and income.

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. 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 CareDirect 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, I will provide Chiesi CareDirect additional documentation to authenticate the statements made on my application when periodically requested. 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. I also agree to promptly notify Chiesi CareDirect if my insurance coverage or income changes during my enrollment. The information above will append the incomplete information provided on my original enrollment application.

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

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Patient Assistance Program

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PO Box 30317
Bethesda, MD 20824-0317

Healthcare Provider Section – A Licensed healthcare provider must complete this section

Name (as it appears on your State License):

Professional Designation (MD, DO, NP, PA, etc.)

Office Address (no PO Boxes): Suite #:

City: State: ZIP Code:

NPI Number: DEA Number:

State License Number:

Office Contact Name:

Phone: Fax: Email:

Attach a valid prescription for BRONCHITOL (mannitol) inhalation powder or PERTZYE (pancrelipase) to this application or complete prescription below, if permitted by law

Healthcare Provider Disclaimer and Signature

My signature certifies that I am a licensed healthcare provider eligible under state law, my collaborative agreement and formulary, if applicable, to prescribe, receive, and dispense the requested drug listed on this application, delivered by CareMetx Health through the Chiesi CareDirect Patient Assistance Program (the "Program"). I further certify all information provided in the above Section and on the prescription is correct and complete and agree to submit appropriate verification of such information upon reasonable request. I agree that the drug provided to me by the Program pursuant to prescription provided to me for the applicant named above will be provided by me to such eligible patient for his or her own use without charge. I will not otherwise use any of such drug or prescribe, provide, or dispense all or any portion of thereof for the use of any other person. I further consent that the Program may perform, on-site audit of Program records related to the applicant named above. I understand that I am not eligible to and certify that neither I nor my office will: (i) seek reimbursement for any drug dispensed by the Program from any individual, government program, or third-party insurer; the applicants Medicare Par D TrOOP (if applicable). I further understand that I cannot seek payment for an office visit from the applicant or third-party insurer when Program drug is provided to the applicant. I also understand that an individual patient's eligibility or continued eligibility under the Program is subject to Chiesi USA's discretion and that the Program reserves the right to modify or terminate the Program at any time. I further understand my enrollment is subject to Chiesi USA's discretion and Chiesi USA reserves the right to terminate at any time.

Licensed Healthcare Provider's Original Signature (Required):

Date:

Prescription Information Section

Patient First Name: M.I.: Last Name:

Diagnosis/ICD 10 Code:

MEDICATIONS	DOSING INSTRUCTIONS	QTY	REFILLS
□ BRONCHITOL (mannitol) inhalation powder 4-week Treatment Pack (4 x 7-day treatment packs)			
□ PERTZYE (pancrelipase) 4,000 USP Lipase Units			
□ PERTZYE (pancrelipase) 8,000 USP Lipase Units			
□ PERTZYE (pancrelipase) 16,000 USP Lipase Units			
□ PERTZYE (pancrelipase) 24,000 USP Lipase Units			
Physician Signature:		Date:	