TevaCares FOUNDATION

PO Box 16130, Columbus, OH 43216
Phone: 877-237-4881
Fax: 877-438-4404

Thank you for your interest in the TEVA CARES FOUNDATION Patient Assistance Program which provides prescription medicines at no cost to patients who qualify. If you have no prescription drug coverage and meet the program income guidelines, you may qualify for this program. Please complete and submit this application to determine if you qualify. Each application will be considered on a case by case basis.

PATIENT INSTRUCTIONS: (An incomplete application will delay processing)

1. Complete ALL fields on page 1.
2. Read the Patient Certification and Patient Authorization to Use and Disclose Protected Health Information statements on Page 2. IMPORTANT: Provide printed and signed name, and date of signature in the spaces provided after each statement.
3. Proof of income is required from all sources and for all members of your household (you, your spouse and your dependents). Provide Proof of Income in one of two ways:
   - For your convenience, let us verify your income securely and electronically by consenting to Electronic Income Verification on Page 3, OR
   - Attach Proof of Income, which may include one or more of the following:
     - A copy of your most recently filed Federal Income Tax Return or Forms (1040, 1040EZ, 1099, 1099-DIV or 1099-INT)
     - Social Security Income Yearly Benefits Statement (SSA, 1099-R, or Awards Letter)
     - IRS Transcript
     - Pay stubs
     - Unemployment Letter or Worker's Compensation
     - Veterans Benefits, Alimony/Child Support, Rental Income, etc.
     - Employer Letter on Company Letterhead
     - Zero Income Letter from social worker, clergy, physician, or patient/family explaining how patient is surviving with no income
4. Coordinate with your physician to submit the completed application and proof of income as described below.

PHYSICIAN INSTRUCTIONS: (An incomplete application will delay processing)

1. Complete the Prescription Information section on page 4. Attach a separate prescription if required by your state's prescription laws.
2. **For Patients with Commercial Insurance:** Where an appeal is required: (i) submit a claim to the patient's insurance company; (ii) if the claim is denied, submit an appeal to the patient's insurance company, prior to requesting free product under this Program; and (iii) provide documentation of the initial denial and appeal denial to the Program. Application will be considered incomplete and will not be processed until documentation is received by the Program.
3. Read the certification language and sign the application as indicated on page 5.
4. If a prescription is faxed, it must be sent directly from the physician's office
5. Submit the completed application and proof of income in one of three ways below:
   - Upload to our secure site: https://hubconnect.mckesson.com/hubconnect/teva
     Note: Prescriptions and Prescription on Page 4 must be faxed separately to 1-877-438-4404
   - Fax everything to: 1-877-438-4404
   - Mail to: TEVA CARES FOUNDATION
     Patient Assistance Program
     PO BOX 16130
     Columbus OH 43216
6. Complete the Product Shipment information on page 4.

If you have any questions please call the program at 877-237-4881. We are available to answer your call Monday through Friday, from 9:00am to 8:00pm Eastern Time (excluding holidays).

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PATIENT INFORMATION:

Patient Name (First MI Last):		
Last 4 Digits of SSN:	Date of Birth:	
Mailing Address:	Phone:	
City:	State:	ZIP:
Contact Name (if other than patient):	Contact Phone:	
Permanent US Resident? ☐ YES ☐ NO		

FINANCIAL INFORMATION:

Number of people in your household including you, your spouse and your dependents:

Total Annual Income for your household listed above (Adjusted Gross Income): $

Provide Proof of Income – Check one box ONLY:

- ☐ Electronic Income Verification: Consent is required for us to electronically verify your income. Provide your consent on Page 3.
- ☐ Income Documentation: Attach copies of Proof of Income from all sources – see complete list of acceptable documents in Patient Instructions on the cover page.

INSURANCE INFORMATION:

Do you have any insurance coverage? ☐ YES ☐ NO

For each policy you have, including any secondary coverage, provide the following:

	Insurance Name:	Phone #:	ID / Policy #:
Primary:			
Secondary:			

Please provide legible copies of the front and back of all insurance cards (enlarged if possible)

Do you have the following insurance coverage?

☐ YES ☐ NO Employer provided or other private/commercial insurance

☐ YES ☐ NO Medicare A or B If yes, list Effective Date: _____

☐ YES ☐ NO Medicare Advantage

☐ YES ☐ NO Medicare Part D

☐ YES ☐ NO Medicaid
What is your Medicaid status for the past 12 months? ☐ Not applied ☐ Denied ☐ Pending

Veterans:

☐ YES ☐ NO Are you a Veteran or a spouse or dependent of a Veteran who is eligible for VA benefits?
If yes, have you applied for VA benefits? ☐ YES ☐ NO

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PATIENT CERTIFICATION:

I certify that the information I have provided is truthful and accurate to the best of my knowledge. I understand that any assistance provided to me through the Teva Cares Foundation ("The Foundation") Patient Assistance Program (the "Program") is contingent upon my ability to meet the eligibility criteria for the Program as established by The Foundation and that my application for assistance does not guarantee acceptance into the Program. Any assistance for which I may be eligible will only be awarded after my documentation has been received and approved by the Program. In the event that I am eligible for the Program, I acknowledge that this assistance is temporary and that I may be asked to reapply at designated intervals as determined by the Program. Assistance is not guaranteed for any specific time frame and may be terminated at any time for any reason without any notice to me. I agree that I will notify the Program within thirty (30) days if my insurance or financial situation changes as this may impact my eligibility to participate in the Program. The Program has the right to review its records periodically throughout a patient's enrollment period to verify that the enrolled patient continues to satisfy the eligibility criteria. If this review determines that the patient no longer satisfies the eligibility criteria, the PAP will withdraw the patient from the Program. I certify that I have not received and will not seek to receive reimbursement for the Teva drug requested and/or supplied through the Program. I agree that the Program and its affiliates, agents and representatives shall not be liable for any damages, of any kind, without limitation, in connection with my receiving assistance, benefits, or services provided by the Program. I have read, understand, and agree to all of the above.

Print Patient or Personal Representative Name: _____

If Personal Representative, please state legal authority: _____

Signature Required

Patient or Personal Representative Signature: _____ Date: _____

*If signed by Personal Representative, we may contact you if additional documentation is required.

PATIENT AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION:

I authorize my healthcare providers, pharmacies and health plan(s) to disclose my personal health information on this form as well as information related to my medical condition, treatment, care management, prescriptions and health insurance to the Teva Cares Foundation ("The Foundation") and its affiliates, contractors and agents, including its third party patient assistance program service provider (collectively "Teva") for the purposes described below.

I understand that the purpose of this Authorization is to provide me with access to services related to my prescribed medication and/or medical condition, including (i) enrollment in the Program; (ii) conducting benefits investigation and coordinating my insurance coverage, which may include allowing a Teva field based representative to access my information and engage with my healthcare providers directly, if necessary; (iii) if needed, determining my eligibility for and coordinating financial assistance; (iv) coordinating prescription fulfillment and product replacement; (v) providing nursing support, including product administration training and education; (vi) facilitating quality and adverse event reporting activities; (vii) conducting data analytics, market research and Program related business activities; (viii) providing me and/or the person legally authorized to sign on my behalf with educational materials, information, and services related to the Program.

I understand that I may cancel this Authorization at any time, by writing to The Foundation, Attn: Authorizations, P.O. Box 16130, Columbus, OH 43216, but my cancellation will not apply to any information already disclosed pursuant to this Authorization. This Authorization will remain in effect until the Program ends. I understand that once my information is disclosed, it may be subject to re-disclosure by the recipients and no longer protected by federal privacy law. I understand that my treatment, payment for treatment, insurance enrollment, or eligibility for insurance benefits will not be directly affected if I do not sign this Authorization. However, if I do not sign this Authorization, I may not be able to receive Program services. I am also entitled to a copy of this signed Authorization.

Print Patient or Personal Representative Name: _____

If Personal Representative, please state legal authority: _____

Signature Required

Patient or Personal Representative Signature: _____ Date: _____

*If signed by Personal Representative, we may contact you if additional documentation is required.

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FAIR CREDIT REPORTING ACT PATIENT CONSENT FOR ELECTRONIC INCOME ESTIMATION:

I am providing 'written instructions' under the Fair Credit Reporting Act to the program, including its agents, administrators and service providers, authorizing the program to obtain information from my credit profile and/or other information from Experian Health. I authorize the Program, including its agents, administrators, and service providers, to obtain such information solely to determine my eligibility to participate in the program. I understand this is a soft inquiry that will not affect my credit score or be visible to lenders viewing a credit report. I also understand that if my income cannot be estimated electronically, or if my estimated income determines me ineligible, the Program will reach out to me for proof of income documentation. I further understand that upon request, the Program will inform me whether it accessed this information and the name and address of the agency that furnished it.

Print Patient or Personal Representative Name: _____

If Personal Representative, please state legal authority: _____

Signature Required

Patient or Personal Representative Signature: _____ Date: _____

*If signed by Personal Representative, we may contact you if additional documentation is required.

TELEPHONE CONSUMER PROTECTION ACT AUTHORIZATION:

By signing, I agree to be contacted by email at the address I have provided or to receive autodialed phone or text messages ("texts") at the mobile phone number I have provided for the purpose of helping me/the patient stay on therapy, which may promote or advertise for Teva products.

I certify that the number I am providing belongs to me and not a family member or third party.

I understand that I may opt out of individual communications of the program entirely at any time by calling 877-237-4881 clicking the email link in a message received or by replying "STOP" by text to any text from Teva Cares.

Teva Cares will not sell or rent this information and will use it only in accordance with this authorization and consent.

Consent to being contacted by email, phone or text messages is not a condition of participation in the programs or the purchase of any products or services. I understand that my cellular service carrier's data and text messaging rates may apply.

If I am providing this consent on behalf of another person, I certify that I am authorized to agree to every element of this consent on behalf of such other person, and I agree that I will be liable and will hold Teva Cares harmless in the event that such other person alleges that they did not give consent.

Print Patient or Personal Representative Name: _____

If Personal Representative, please state legal authority: _____

Signature Required

Patient or Personal Representative Signature: _____ Date: _____

*If signed by Personal Representative, we may contact you if additional documentation is required.

The remainder of this page is blank.

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Prescriber: Please attach a separate prescription if required by your state's prescription laws.

PRESCRIPTION:

Patient Name (First MI Last):		Date of Birth:
Address:		
City:	State:	ZIP:
Health Conditions:		
Is patient being treated outpatient: ☐ YES ☐ NO		

Therapy GIVEN			Therapy PLANNED for month		
Date(s)	Dose	Frequency	Date(s)	Dose	Frequency

Medication Allergies:

Medications Currently Taking:

☐ Ship to Patient ☐ Ship to Office

If shipping address is different than the address provided, list below.
Medication Shipping Address:

City:	State:	ZIP:

Medications Available: BENDEKA® (bendamustine HCl), Cyclosporine Capsules, Cyclosporine Oral Solution Modified, GALZIN® (zinc acetate) Capsules, GRANIX® (tbo-filgrastim), PROGLYCEM® (diazoxide) Oral Suspension

Product Requested:	Strength:	Quantity:	Frequency/Directions:	Refills:
☐ _____				☐ _____ ☐ 1 Year

PRESCRIBER SIGNATURE:

Signature Required

Prescriber's Signature:		Date:
Physician Name:		
NPI #:		
Facility Name:		
Mailing Address:		
City:	State:	ZIP:
Medicaid Provider # & Pin:		
Clinic Contact:		Contact Title:
Contact Phone:	Ext:	Contact Fax:

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PHYSICIAN CERTIFICATION:

On behalf of my patient, I request assistance for the drug specified in this application. I attest that the information contained in this form is complete and accurate to the best of my knowledge and that based upon my professional judgment, the drug I have prescribed and specified in this application is medically necessary. I authorize Teva Cares Foundation and its affiliates, business partners, and agents to forward, as my agent for these limited purposes, this prescription electronically, by facsimile, or by mail to the appropriate dispensing pharmacies. I certify that I have a signed copy on file of my patient's current and completed Patient Authorization so that I may share this patient's health information with Teva Cares PAP. Should any information contained in this form change, I agree to notify a Program representative. I understand that the patient must meet certain financial criteria to be eligible under the Program and that completing this enrollment form does not guarantee that assistance will be provided to my patient. I certify that I have not received, and will not seek to receive, reimbursement for any drug requested and/or supplied under the Program and any administration charges will be consistent with my practice's standard policies for treatment of and charges to financially needy patients. I certify that no free product provided under this Program will be distributed for sale to any individual or organization or returned for credit. I understand that the Teva Cares Foundation reserves the right to modify or terminate this Program at any time for any reason without any prior notice. I understand that I am under no obligation to prescribe a specific drug and I have not received, nor will I receive any benefit, for prescribing a specific drug.

Signature Required

Prescriber Signature: _____ Date: _____

The remainder of this page is blank.