



## Patient Assistance Program Enrollment Form

Required fields are marked with an asterisk (\*).

<b>Patient Contact Information</b>	1. First Name*	2. Last Name*	3. Date of Birth* (MM/DD/YYYY)	4. Birth Sex* <input type="checkbox"/> Male <input type="checkbox"/> Female
	5. Home Address*	6. City*	7. State*	8. Zip Code*
	9(a). Does patient have a Patient Representative (e.g. parent, guardian, healthcare power of attorney)? <input type="checkbox"/> Yes <input type="checkbox"/> No		9(b). If "Yes", Name of Patient Representative	
	10. Patient or Patient Representative Phone #* ( <input type="checkbox"/> Home <input type="checkbox"/> Cell)		11. Patient or Patient Representative Email (optional)	
	12. Best time to contact* <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening	12(a). OK to leave voicemail* <input type="checkbox"/> Yes <input type="checkbox"/> No	13. Preferred Language	
<b>Patient Insurance Information</b>	14. Patient has (select all that apply)* <input type="checkbox"/> No insurance <input type="checkbox"/> Medicare B <input type="checkbox"/> Medicare Advantage <input type="checkbox"/> Medicaid <input type="checkbox"/> Private/Commercial <input type="checkbox"/> Other Government (TRICARE/VA)			
	15. Pharmacy Benefit Plan Name			
	16(a). Policy Holder Name		16(b). Insurance Phone #	
	16(c). RX BIN	16(d). RX PCN	16(e). ID#	16(f). Rx Group #
<b>Patient Clinical Information</b>	17. Diagnosis* (select one) <input type="checkbox"/> Z94.0 Kidney transplant status (ICD-10)		<input type="checkbox"/> Other (specify)	
	18. Date of Transplant*	19. Did Medicare pay for transplant* (select one)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	20(a). Estimated total daily dose of ENVARSUS XR® (tacrolimus extended-release tablets)*		21(b). Dosage Strength Prescribed* <input type="checkbox"/> 0.75 mg <input type="checkbox"/> 1 mg <input type="checkbox"/> 4 mg	
<b>Healthcare Provider Information</b>	21. Prescriber First Name*		22. Prescriber Last Name*	
	23. Prescriber NPI #*			
	24. Organization Name			
	25. Organization Address	26. City	27. State	28. Zip Code
	29. Organization Phone*		30. Organization Fax*	
	31. Organization Contact Name*			
	32. Organization Contact Email (optional)			33. Preferred Contact Method* <input type="checkbox"/> Phone <input type="checkbox"/> Fax <input type="checkbox"/> Email
	<p>By submitting this form, the Prescriber and Organization certify the following statements:</p> <p>(i) The information provided in this form is current, accurate, and complete. (ii) ENVARSUS XR® (the Product) has been determined by the Prescriber to be medically necessary for the patient, the patient is prescribed the Product for an FDA-approved indication, and the patient meets the eligibility requirements for the Veloxis Transplant Support Patient Assistance Program (the PAP Program). (iii) Prescriber and Organization have the necessary authorization and consents on file to share personal information with third party service providers of Veloxis Pharmaceuticals, Inc. (Authorized Representatives) in connection with their treatment. (iv) Prescriber and the Organization will not submit or cause submission of any claims for payment or reimbursement in connection with the PAP Program to third-party payers including without limitation Medicare or Medicaid. (v) Prescriber and Organization are under no obligation to prescribe the Product or participate in the PAP Program. (vi) Prescriber and Organization have not and will not receive any benefit from Veloxis for prescribing any Veloxis products. (vii) Veloxis may suspend Prescriber and/or Organization's participation in the PAP Program at any time. (viii) Prescriber and Organization understand that Veloxis and its Authorized Representatives are relying upon the accuracy and completeness of this certification.</p>			

### ePrescribe or Fax 90-day prescription to:

United BioSource Pharmacy, LLC  
Creve Coeur, MO  
NPI: 1962978858

Address:  
600 Emerson Rd Suite 300  
Creve Coeur, MO 63141

Toll-Free: 855-822-7948  
Fax: 866-750-9260

## Patient Consent and Privacy Notice

### Patient Certification/Agreement

- 1. Signatures.** Your signature will be valid for a period of 3 years. **If you are completing this form on behalf of a patient**, you certify that you are the parent or legal guardian of a 17-year-old patient **OR** you have healthcare power of attorney for the patient. References to "you" or "your" below refer to the patient. By signing this document you are:
  - Agreeing to terms and conditions of the Veloxis Transplant Support Patient Assistance Program (the PAP Program),
  - Agreeing to your obligations below, and
  - Consenting to the collection and use of your personal information (including income verification).
- 2. Eligibility Criteria.** Your enrollment is not guaranteed. Your participation in the PAP Program is subject to the following criteria: (i) you are commercially or federally underinsured or uninsured, (ii) you meet financial eligibility criteria, (iii) you are a kidney transplant recipient, (iv) you are age 17 or older, and (v) you are a resident of the US or its territories.
- 3. Income Verification.** Authorized Representatives will conduct electronic income verification using third party consumer credit reporting agencies (e.g., Experian). If electronic verification cannot be done, you will be asked for verifiable documentation of your household income. Your household is limited to you, your spouse, and your dependents. Income verification will happen annually.
- 4. Personal Information.** Veloxis is committed to your privacy and will use appropriate measures to protect your personal information. Your information is necessary to: (i) Enroll me or initiate my enrollment in the PAP Program; (ii) Establish my benefit eligibility and to provide me with related services, including directing me to reimbursement services, services to ship my medication, and other support services (if and to the extent applicable); (iii) Perform research and data analytics to develop and evaluate products, services, materials, and treatments, and improve the PAP Program; (iv) Communicate with my healthcare providers and health plans about my treatment plan; (v) Contact me for reasons related to the PAP Program and all support services or to obtain further information or clarification regarding any adverse event that I may experience; and (vi) Help get medication delivered. Your information includes your contact information, insurance or pharmacy benefits information, transplant information, and prescription information. Neither Veloxis nor its Authorized Representatives will sell your information or share your information with third parties other than Authorized Representatives. Authorized Representatives are compensated by Veloxis for their services to Veloxis and not in exchange for your information. Authorized Representatives will collect information from you, your healthcare provider's office, pharmacies, or consumer credit reporting agencies. Telephone calls may be recorded for quality and other purposes related to the PAP Program. Your information will be kept as long as necessary to manage your enrollment and participation in the PAP Program. Veloxis will not receive your identifiable information, however Authorized Representatives may provide Veloxis with de-identified reports about the PAP Program. You may have certain legal rights according to the privacy laws where you live such as the rights to access or correct your information. You may revoke your consent to use of your information. **However, revoking your consent means you will no longer be able to participate in the PAP Program.** You may send questions or requests regarding your information in writing to [help@veloxistransplantsupport.com](mailto:help@veloxistransplantsupport.com).
- 5. Your Obligations.** You certify that your application is complete and accurate. You will promptly notify the Authorized Representative at [help@veloxistransplantsupport.com](mailto:help@veloxistransplantsupport.com) regarding changes to your information (e.g., changes to your household income, change of address, change of contact information). Failure to promptly update your information may delay communications about the PAP Program or receipt of your medication. Failure to provide necessary information to an Authorized Representative upon request may affect your eligibility for the PAP Program. You will not submit any claim to an commercial insurer, federal insurer, or pharmacy benefit plan. If you have Medicare Part D coverage, you will not have the cost/value of the PAP Program medication counted as out-of-pocket costs for program medication and will inform your plan about your enrollment. You will not sell, trade, or transfer any PAP Program medication. You are responsible for any messaging or data costs associated with text messaging.

### Income Verification

I authorize Veloxis Transplant Support, and its Authorized Representatives, to attempt to verify my household income electronically

Including me, I/we have \_\_\_\_\_ (number) of dependents in our household.

If electronic verification is not authorized, you will have to provide alternative proof of income to process this application.

Patient's or Patient Representative's Printed Name

Patient's or Patient Representative's Signature

Relationship to Patient (if not self)  Legal guardian  Healthcare Power of Attorney