PATIENT ASSISTANCE PROGRAM
PHONE: (888) 958-5502 | FAX: (888) 958-1725

PATIENT ASSISTANCE PROGRAM ELIGIBILITY AND GUIDELINES

▪ The application must be completed in its entirety
▪ FAX the application with requested documentation to the address above
▪ The patient must be a U.S. Resident with a valid Social Security Number
▪ The patient must have a household income at or below 300% of the current Federal Poverty Level
▪ The patient must not have prescription insurance coverage, or must be underinsured as defined by the program
▪ Patients who meet certain rules will be able to get their prescribed medications free of charge for up to one year
▪ Every year, the patient must reapply, and be accepted, to continue in the program

FOR THE HEALTHCARE PROVIDER

▪ The application must be completed with an original signature. Stamp signatures are not accepted.

FOR THE PATIENT

▪ The application must be completed in its entirety with an original signature and date.
▪ You must reapply to the program annually, including the completion of a new application with a new original signature and date
Patient Assistance Program
Please complete form in full, sign and date, and fax to (888) 958-1725

Patient Information

Name: ___________________________ Date of Birth: _____ / _____ / _____ SSN: _____ – _____ – _____ Gender: [ ] Male [ ] Female

Address: ____________________________________________________________ City: __________________________ State: ___________ ZIP: ___________

Home Phone: ( ______ ) ___________ Cell Phone: ( ______ ) ___________ Are you a US Resident? [ ] Yes [ ] No

Total Annual Household (HH) Income: $ __________________________ Household Size (circle selection): 1 2 3 4 5 6 ___________

Insurance Information

Please Select Your Pharmacy Insurance Coverage Type: (select all that apply, please provide copies of insurance cards with the application)

[ ] Private/Commercial [ ] Medicare Part D [ ] Medicare Advantage [ ] Medicaid [ ] VA or Military [ ] No Pharmacy Benefit [ ] No Insurance (Uninsured)

Pharmacy Plan Name: ___________________________ Phone: ___________________________ Pharmacy ID/Policy#: ___________________________

BIN: ___________ PCN: ___________ Rx Group: ___________ Policyholder Name & DOB: ___________________________

Patient Authorization & Signature

I hereby authorize my healthcare providers, my health insurance carriers, and my pharmacies to use and disclose my individually identifiable health information, including my medical records, insurance coverage information, and my name, address and telephone number to Horizon Therapeutics plc and its affiliates and their respective agents and representatives (collectively, “Horizon”), including third parties authorized by Horizon to administer drug support and to dispense drugs for the following purposes: (1) to establish eligibility for benefits; (2) to communicate with my healthcare providers and me about my treatment or condition and related products; (3) to facilitate the provision of products, supplies, or services by a third party including, but not limited to, specialty pharmacies; (4) to register me in any applicable product registration program required for my treatment; (5) to enroll me in eligible patient support programs offered Horizon, including nursing or patient access support services (government-reimbursed programs may not be eligible for all support services offered; please contact Sonexus Health, LLC at (888) 958-5502 for determination); and (6) to send me marketing information or offer me products and services related to my treatment or condition (or related products or services in which I might be interested) and to contact me occasionally to obtain my feedback (for market research purposes only) about my treatment, my condition, or my experience with Horizon otherwise as required or permitted by law. I understand the pharmacies may receive a fee from Horizon in exchange for (1) providing me with certain materials and information described above, and (2) using or disclosing certain health information pursuant to this Authorization.

I understand that Horizon, as well as my healthcare providers, cannot require me, as a condition of having access to medications, prescription drugs, treatment, or other care, to sign this Authorization. I understand that I am entitled to a copy of this Authorization. I understand that information disclosed pursuant to this Authorization in some cases may be redisclosed by the recipient and no longer protected by HIPAA or other privacy laws. But Horizon has agreed to use and disclose my information only for purposes of operating the program.

I also understand that I am providing ‘written instructions’ to Horizon and its representative Sonexus Health under the Fair Credit Reporting Act authorizing Sonexus Health, on behalf of Horizon, to obtain information from my credit profile or other information from Experian Health. I authorize Horizon and Sonexus Health to obtain such information solely for determining financial qualifications for the Horizon Patient Assistance Program (PAP). I understand that I must affirmatively agree to the terms in this notice by signing below to proceed in the PAP financial screening process.

I understand that I may cancel this Authorization at any time by mailing a signed letter requesting such cancellation to Sonexus Health, 2730 S. Edmonds Lane, Suite 300, Lewisville, TX 75067, but that this cancellation will not apply to any information used or disclosed by my healthcare providers and/or health insurance carriers based on this Authorization before they are notified that I have cancelled it. Unless required by state law, this Authorization is valid for whichever is greater: (a) the duration of remaining on this treatment or (b) 10 years from the date signed below. A photocopy of this Authorization will be treated in the same manner as the original.

Patient Authorization: My signature certifies that I have read and understand the above statements, and agree to the outlined terms.

Patient’s/Legally Authorized Representative’s Signature: ___________________________

Patient’s/Legally Authorized Representative’s Printed Name (if required): ___________________________

Patient’s/Legally Authorized Representative’s Home Address: ___________________________

City: __________________________ State: ___________ Zip Code: ___________

Patient’s/Legally Authorized Representative’s Telephone: ___________________________

Patient’s/Legally Authorized Representative’s Email Address: ___________________________

Patient’s/Legally Authorized Representative’s Relationship to Patient: [ ] Spouse [ ] Parent/Legal Guardian [ ] Representative by Power of Attorney

Is there someone else with whom we may discuss your protected health information? [ ] No [ ] Yes

Name: ___________________________ Relationship to you: ___________________________

Name: ___________________________ Relationship to you: ___________________________

Prescriber Information

Prescriber Name: ___________________________ Prescriber NPI: ___________________________

Facility Name: ___________________________ State License #: ___________________________

Facility Address: ___________________________ City: __________________________ State: ___________ ZIP: ___________

Primary Office Contact: ___________________________ Fax Number: ___________________________

Phone Number: ( ______ ) ___________ Office Contact Email: ___________________________
### Prescription & Diagnosis Information

<table>
<thead>
<tr>
<th>Product</th>
<th>Dose</th>
<th>Quantity</th>
<th>Refills</th>
<th>Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>RAYOS® (prednisone) delayed-release tablets</td>
<td>1 mg</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>2 mg</td>
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<td></td>
<td>5 mg</td>
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<td></td>
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<tr>
<td>VIMOVO® (naproxen and esomeprazole magnesium) delayed-release tablets</td>
<td>375 mg/20 mg</td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>500 mg/20 mg</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DUEXIS® (ibuprofen and famotidine) tablets</td>
<td>800 mg/26.6 mg</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PENNSAID® (diclofenac sodium topical solution) 2% w/w</td>
<td>40 mg (2 pump actuations), 2 times a day</td>
<td>1 bottle</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Allergies:** [ ] No Known Allergies  Other Medications: 

**Diagnosis:** (include diagnosis description) __________________________________________________________

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### Prescriber Certification & Prescription Signature

By signing this prescription, I certify that I have prescribed the requested Horizon (as defined above) medication to treat this patient for an indication that is within the medication’s approved labeling, and that I will supervise the patient’s medical treatment. I certify that the information provided is complete and accurate to the best of my knowledge, and that I shall not seek reimbursement for this medication from any third party. I understand that Horizon will use this information to administer the HORIZONCares™ program (the “Program”), which provides assistance to patients in verifying insurance coverage for the Horizon medications listed above and assistance in initiating or continuing the Horizon medications as prescribed. By my signature, I also certify that my patient or his/her personal representative has provided a signed HIPAA authorization that allows me to share Protected Health Information with Horizon for purposes of the Program. I appoint the Program, on my behalf, to proceed with services offered and to convey this prescription to the dispensing pharmacy, to the extent permitted under state law. I further understand and agree that (a) any medication or service provided through the Program as a result of this form is for the named patient only and is not being made in exchange for any express or implied agreement or understanding that I would recommend, prescribe, or use the Horizon medications, or any other Horizon product or service, for any other person, (b) my decision to prescribe the Horizon medications was based solely on my professional determination of medical necessity, and (c) I will not seek reimbursement for any medication or service provided by or through the Program from any government program or third-party insurer. I understand that Horizon may modify or terminate the Program at any time without notice.

State requirements: The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Noncompliance with state specific requirements could result in outreach to the prescriber.

By filling out this form, your patient is automatically enrolled into the Program unless the box below is checked.

[ ] Check here if you choose not to enroll this patient into the Program.

**Prescriber Name:** [ ] Date:

(Original signature required. *If required by applicable law, please attach copies of all prescriptions on official state prescription forms)

**Prescriber Signature:** __________________________

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